COLLEGE of AMERICAN PATHOLOGISTS

Spring 2015 House of Delegates Meeting Agenda

March 21, 2015
Boston, Massachusetts

COLLEGE of AMERICAN PATHOLOGISTS

HOD is Going Green in Twenty15

A **limited** number of printed agenda books will be available at the Spring ’15 HOD meeting. Wireless Internet access will be available in the HOD meeting ballrooms for your convenience.

Please download the electronic Spring ’15 HOD agenda to your smart device prior to the meeting – and **go green** with us in 2015.

Agenda Book Contents

COLLEGE of AMERICAN PATHOLOGISTS

Meeting: **House of Delegates**
Date: March 20-21, 2015
Location: Westin Copley Place, 10 Huntington Avenue, Boston, MA 02116
t: 617-262-9600 | **w:** http://www.westincopleyplaceboston.com/
Staff: Jan Glas | **t: 847-832-7499** | **c:** 262-497-5197 | jglas@cap.org
Maryrose Murphy | **t: 847-832-7499** | mmurphy@cap.org
Patricia Tennant | **t: 847-832-7499** | ptennan@cap.org
Marci Zerante | **t: 847-832-7499** | mzerant@cap.org

Friday, March 20	**Event**	**Location**
5:00–6:30 PM	Welcome Reception	Staffordshire Room, 3rd Floor
Saturday, March 21		
7:00–8:00 AM	Breakfast	American South, 4th Floor
8:00–9:00 AM	Joint HODRF Session	American South, 4th Floor
9:30 AM–12:00 PM	House of Delegates	American Center, 4th Floor
12:00–1:15 PM	Joint HODRF Lunch	American South, 4th Floor
1:30–4:00 PM	House of Delegates	American Center, 4th Floor
4:00–6:00 PM	Networking Reception	American Foyer, 4th Floor

House of Delegates and Residents Forum Spring ’15 Joint Session
Saturday, March 21, 2015, Boston, Massachusetts

Time	Duration	Topic	Presenter
7:00-8:00 AM	1 hr	HOD and RF Joint Breakfast	
8:00-8:05 AM	5 min	Welcome	James E. Richard, DO, FCAP
8:05-8:10 AM	5 min	State of the House of Delegates	James E. Richard, DO, FCAP
8:10-8:15 AM	5 min	State of the Residents Forum	Lauren Stuart, MD, MBA
8:15-8:30 AM	15 min	CAP CEO Update	Charles Roussel
8:30-8:45 AM	15 min	CAP President Update	Gene N. Herbek, MD, FCAP
8:45 AM		Closing Remarks	Lauren Stuart, MD, MBA

House of Delegates Spring ’15 Meeting Agenda

Time	Duration	Topic	Presenter
9:00-9:30 AM	30 min	Sign-In and Pick up Badge	
9:30-9:35 AM	5 min	Welcome & Meeting Overview	Michael Misialek, MD, FCAP James E. Richard, DO, FCAP
9:35-9:45 AM	10 min	Strategic Overview	James E. Richard, DO, FCAP
9:45-10:05 AM	20 min	HOD Action Group Updates	Martha Clarke, MD, FCAP Emily Green, MD, FCAP Keith Volmar, MD, FCAP Sang Wu, MD, FCAP
10:05-11:55 AM	1 hr, 50 min	BOG Candidates Forum ‘15 • President-Elect Forum (20 min) *R. Bruce Williams, MD, FCAP* • Secretary-Treasurer Forum (30 min) *Richard R. Gomez, MD, FCAP* *George F. Kwass, MD, FCAP* *Gail Habegger Vance, MD, FCAP* • Governor Forum (50 min) *Edward P. Fody, MD, FCAP* *Gerald R. Hanson, MD, FCAP* *Richard H. Knierim, MD, FCAP* *Raouf E. Nakhleh, MD, FCAP* *Michael B. Prystowsky, MD, PhD, FCAP* *Frank R. Rudy, MD, FCAP* *Allowing 5 minutes between forums*	Moderators: Emily Green, MD, FCAP Martha R. Clarke, MD, FCAP Alfred W. Campbell, MD, FCAP

325 Waukegan Rd.
Northfield, IL 60093
800-323-4040 | cap.org

Time	Duration	Topic	Presenter
11:55 AM-12:00 PM	**Break and pass to lunch**		
12:00-1:15 PM	**HOD/RF Joint Lunch - American South, 4th Floor**		
12:00-12:25 PM	25 min	HOD and RF Lunch	
12:25-12:30 PM	5 min	Welcome & Opening Remarks	Lauren Stuart, MD, MBA
12:30-12:45 PM	15 min	Advocacy Update	George Kwass, MD, FCAP
12:45-1:00 PM	15 min	Q&A	George Kwass, MD, FCAP
1:00-1:10 PM	10 min	PathPAC	Wayne Garrett, DO, FCAP
1:10-1:15 PM	5 min	Closing Remarks	James E. Richard, DO, FCAP
1:15-1:30 PM	**Break and pass to HOD meeting**		
1:30-1:35 PM	5 min	Opening Remarks	James E. Richard, DO, FCAP
1:35-3:05 PM	1 hr, 30 min	Continuing the AP Test Utilization Conversation Q & A	Moderator: Kathryn T. Knight, MD, FCAP
3:05-3:45	40 min	Delegate Chairs Issues Report	James E. Richard, DO, FCAP
3:45-4:00 PM	15 min	Closing Remarks	James E. Richard, DO, FCAP
4:00-6:00 PM	**Networking Reception – American Ballroom Foyer, 4th Floor**		

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CAP House of Delegates

Mission Voice of the Membership

Vision One College

2015 Strategic Initiatives

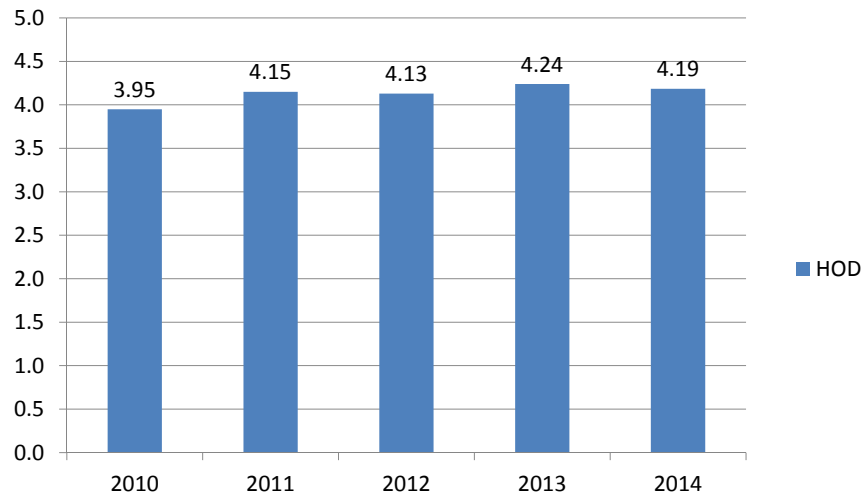
Strategic Initiative	Remarks
Get a Job	The HOD must provide a function that the CAP views as being essential to its operation—a function that won't get done unless the HOD does it. Such a dependency will integrate the HOD inexorably into the infrastructure of the CAP. We must determine what function best provides value to the CAP and meets our talents.
Market the HOD	In realizing our vision of One College, the HOD has in good faith embraced the College. Now things need to go in the other direction. The College must as a routine matter of business embrace the House. We need a mechanism that weaves the HOD into the fiber of the Councils and Committees as an asset that can be mobilized to advance their agendas, missions, and projects.
Strengthen Relationships between Council Chairs and the HOD	We need to strengthen the relationships between Council Chairs and the HOD in a manner that ensures that Delegates view Council Chairs as partners. We must define a way to improve the communications from the HOD to the Council Chairs and from the Council Chairs to the HOD.
Elevate the Stature of House Leadership	The President of the CAP speaks the voice of the membership to the house of Medicine, and the House of Delegates speaks the voice of the membership to the President. We must define and elevate the stature of our position.
Create a Communication Network	Delegates are accountable for communicating to their 18,000-plus constituents and with CAP Leadership. We must develop a communication network that links Delegates to their constituents for the purposes of access, education, and mobilization.

HOD Dashboard Key

- HOD – House of Delegates
- BOG – Board of Governors
- AG – Action Group
- Cmtes – Committees
- C/C's – Councils and Committees

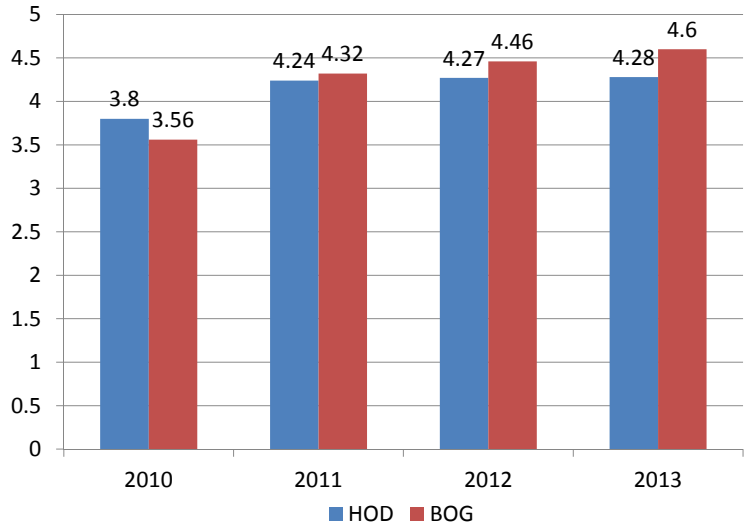
HOD Meeting Format

As of December 2014



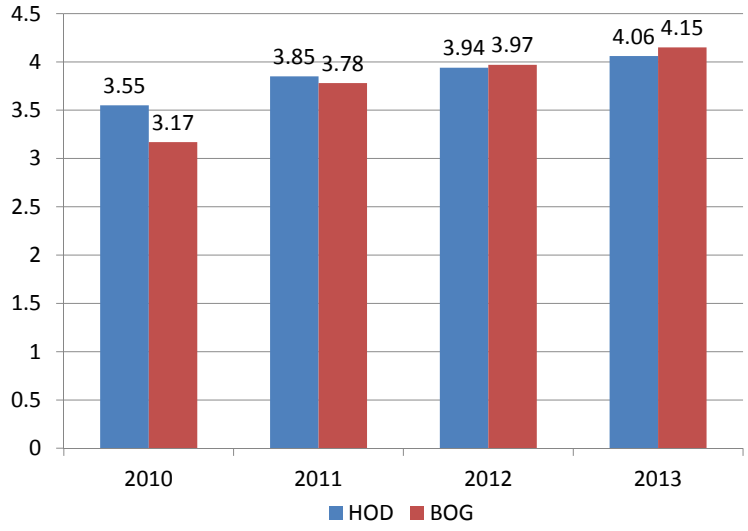
HODSC Effectiveness

As of December 2013



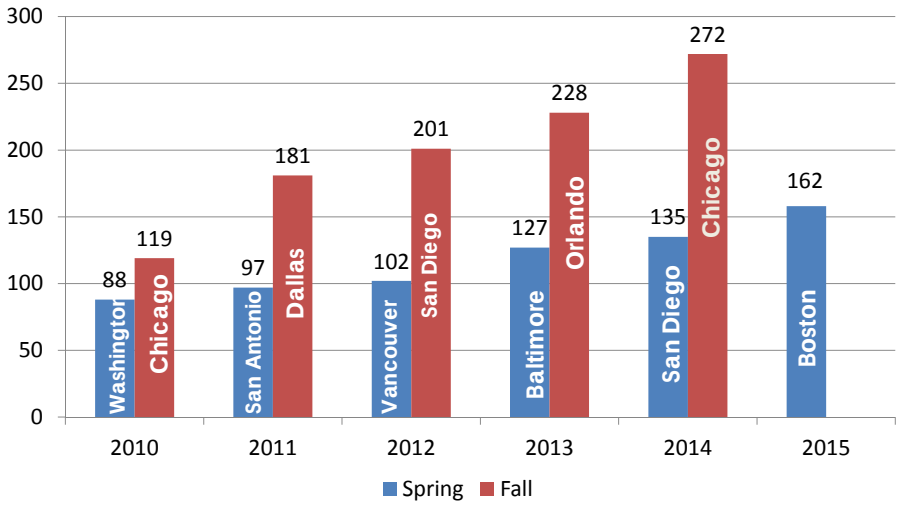
HOD As a Whole

As of January 2014



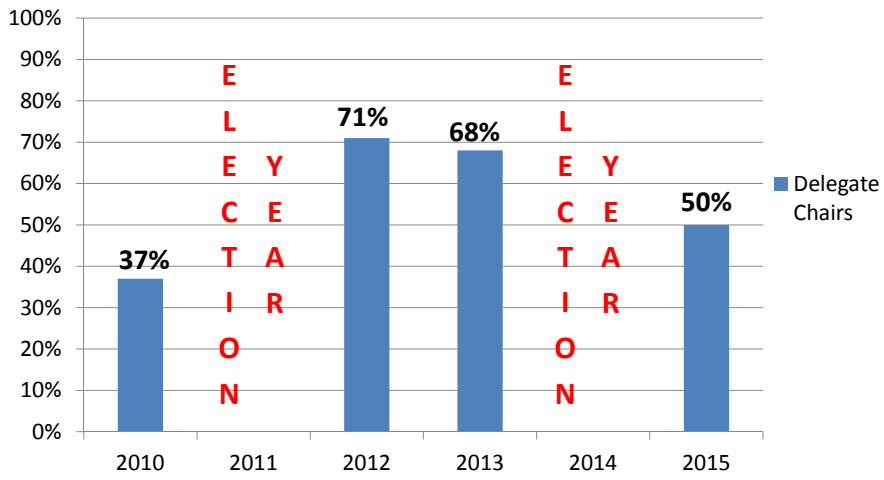
Meeting Registration

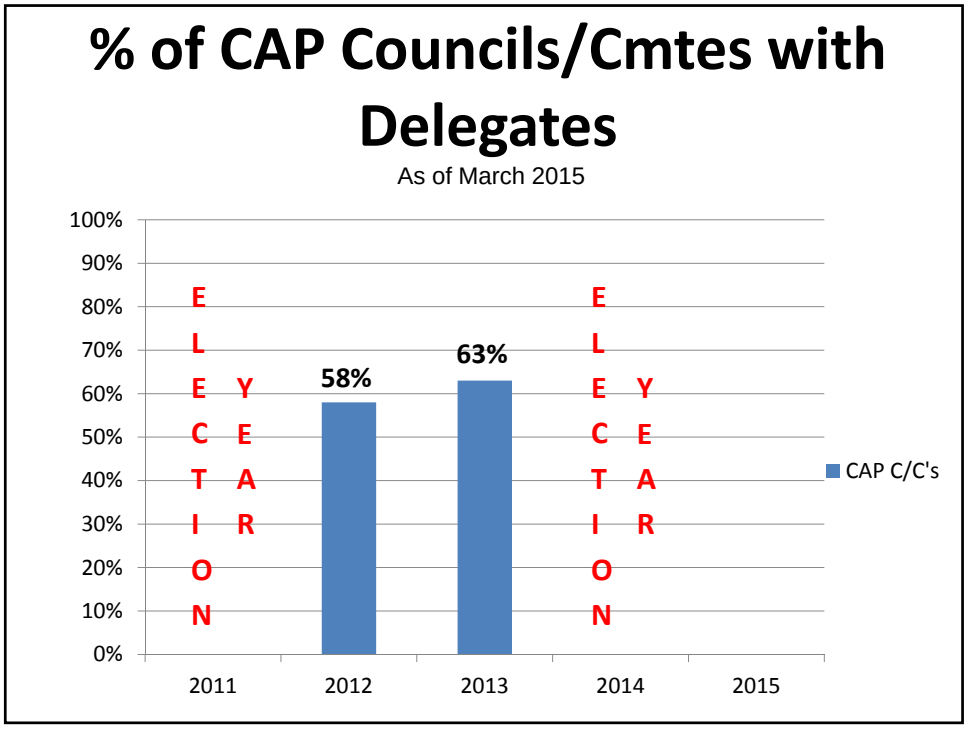
As of March 2015

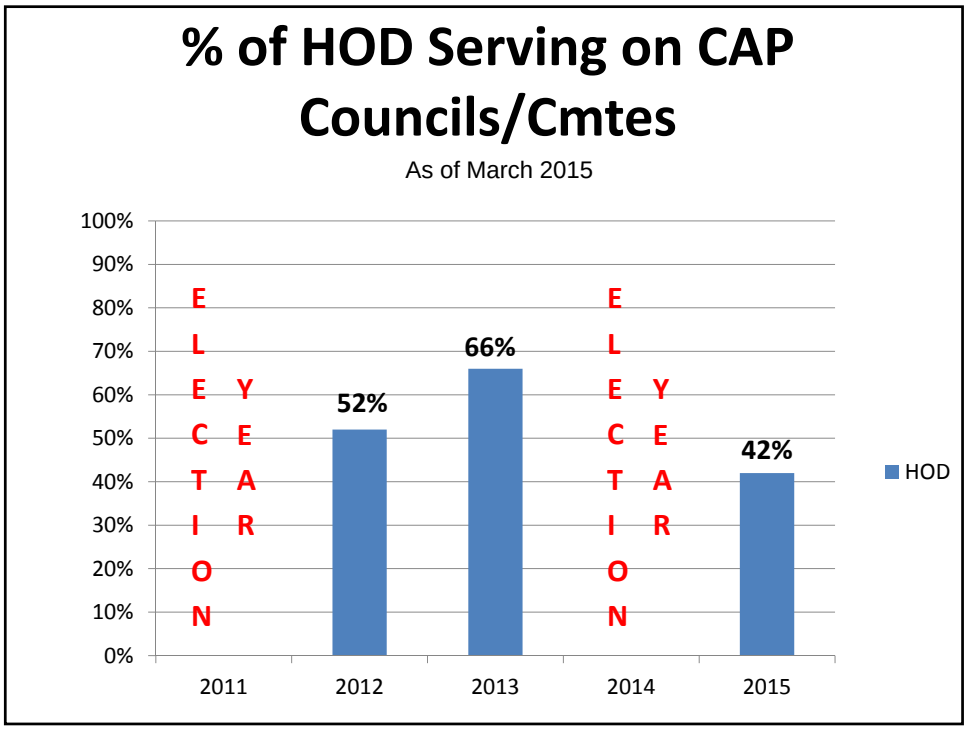


Delegate Chairs Submitting HOD Reports

As of March 2015

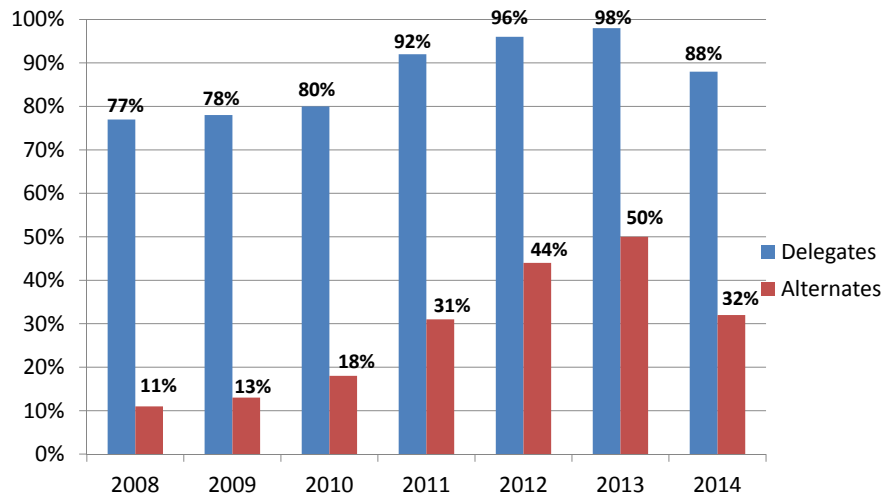



% of CAP Councils/Cmtes with Delegates
As of March 2015
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ELECTION YEAR
58%
63%
2011
2012
2013
2014
2015
CAP C/C's


% of HOD Serving on CAP Councils/Cmtes
As of March 2015
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ELECTION YEAR
52%
66%
42%
2011
2012
2013
2014
2015
HOD

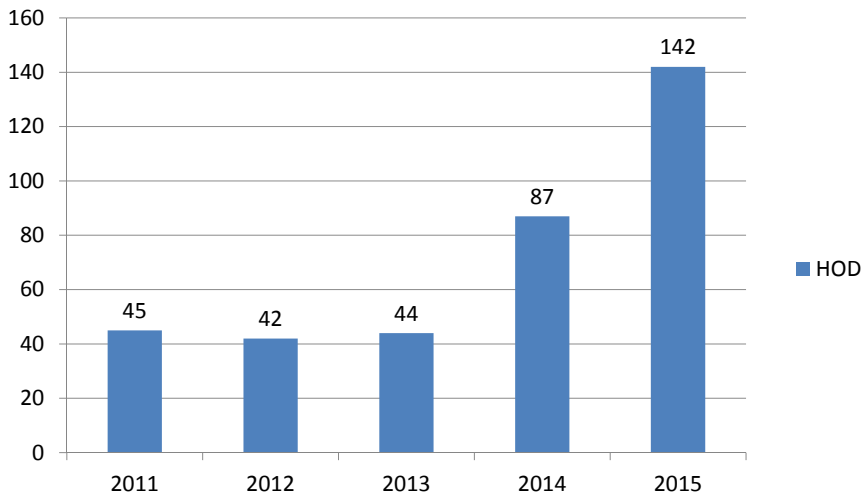
HOD Positions Filled

As of March 2015



AG Engagement Opportunities

As of March 2015



Reports

CONTENTS OF THIS SECTION

HOD Action Group Reports:

- Action Group on Communication Networks
- Action Group on LAP Advisory Group
- Action Group on Pathology Practice Guidances
- Action Group on Rules III

CAP Finance and Council Reports:

- Financial Report from CAP Secretary/Treasurer
- Council on Accreditation
- Council on Education
- Council on Government and Professional Affairs
- Council on Membership and Professional Development
- Council on Scientific Affairs

Topic: **HOD Action Group on Communications Network**

Chair: Keith Volmar, MD, FCAP

HOD Steering Committee Liaison: James E. Richard, DO, FCAP

Members: Mary E. Fowkes, MD, PhD, FCAP, New York Delegate
S. Robert Freedman, MD, FCAP, California Delegation Chair
Rodolfo Laucirica, MD, FCAP, Texas Delegation Chair
Antonio E. Martinez, MD, FCAP, Florida Delegation Chair
Michael Misialek, MD, FCAP, Massachusetts Delegation Chair
Peter Sadow, MD, FCAP, Massachusetts Delegate
Rana Samuel, MD, FCAP, New York Delegation Chair
Vinod Shidham, MD, FCAP, Michigan Delegation Chair
Debra Zynger, MD, FCAP, Ohio Delegation Chair

Date: February 20, 2015

CHARGE

To assist the designated states in reproducing the North Carolina communication network, which is the original pilot prototype.

GOAL

Advance the agenda of the House, in the spirit of ***One College***, and provide value to CAP Councils.

DESCRIPTION

Pilot studies are designed to establish bidirectional conduits linking the House of Delegates to our constituent CAP Fellow Members. The vision is to have Delegate Chairs responsible and accountable for transmitting information to their Delegates and have their Delegates responsible and accountable for transmitting information to CAP Fellows in their states.

STATES IN 2015 PILOT

Contact has been made with each HOD delegation chair in these states:

a. California
b. Florida
c. Massachusetts
d. Michigan
e. New York
f. Ohio
g. Texas

Attachment: Prototype CAP HOD Network Protocol

Prototype College of American Pathologists (CAP) House of Delegates (HOD) Network Protocol

Pilot Prototype: North Carolina Delegation (NCD)
Network Leader: Keith Volmar, CAP HOD Delegate and Network Leader, Raleigh NC
Edited by CAP HOD Steering Committee

Purpose
Create a statewide network by which CAP HOD Delegates may communicate with their CAP Fellow.

Policies and specifications

1. Delegate Chairs or their designees are responsible for organizing, maintaining, and overseeing statewide networks.
2. Networks must offer inclusion to all CAP Fellows residing in the state.
3. Delegations will choose methods of communication (email, phone, letter, social network) that they believe best meet their needs).
4. Networks must devise methods to invite all residents, pathologists regardless of CAP affiliation, and state and state pathology societies. Delegations choose their own methods of linking in state pathology societies and non-CAP-members.
5. Privacy must be maintained. Network contact lists must be protected and not distributed to third parties.
6. Communication content must comprise CAP related matters only. Personal communications and agendas may not utilize the CAP HOD Network.
7. Network design must include methods by which to validate its effectiveness.
8. All communications must be peer-to-peer, i.e. no mass e-mailings to constituents.
9. All Delegates and Alternate Delegates must participate in the Network, e.g., messages pass from Delegate Chairs to Delegates/Alternate Delegates to their apportioned *named* constituents, and vice versa.
10. Email fatigue must be avoided. Email content must be safeguarded. The HODSC will initiate and/or approve all messages prior to release.
11. All e-mail communications must be cc'd to House Speaker.

Procedure for Initial Setup
1. Delegate Chair designates a Network Leader to oversee establishing the network. In most cases, the Delegate Chair will be the Leader.
2. Obtain lists of all pathologists in the state. *For instance, the North Carolina obtained three source lists: State Medical Board, State Medical Society, State Society of Pathologists.*
3. Format the lists uniformly, reconcile the information, and create one master list (e.g. excel spreadsheet). This may take some time and require removing out-of-state pathologists.
4. Apportion state by whatever method works best for your Delegation e.g., geography, congressional district, etc.), practice environment (large, small, academic, etc.). *North Carolina obtained a map of state counties and tallied the constituents in each. (Their state medical board listed pathologists' counties of residence.) They used the map to tally constituents and create regional divisions. Delegations must consider that the network may be utilized for political action and hence may choose to apportion their states by congressional districts. Other*

apportioning systems, for instance those based on type or size of practice might be difficult to manage, as practice arrangements can be fluid.

5. As equitably as possible assign, Delegates/Alternate Delegates to a cell of named constituents. *For instance, the NCD constructed an e-mail network comprising **all** pathologists practicing in North Carolina apportioned by 8 geographical regions, to each of which they assigned a CAP House Delegate.*
6. Provide each CAP Delegate a cover letter explaining the network project. Delegates will distribute this letter to their apportioned constituents when they request their constituents' contact information
7. Have Delegates/Alternate Delegates contact and confirm the e-mail and/or contact information for all pathologists in their assigned area. *The North Carolina Delegation employed the following procedure:*
    a. *For each large community group, recruit a single contact pathologist to obtain/confirm the contact information for all other pathologists in his/her group. Ask that contact person to identify the presence of smaller practices in the area that your original screen did not identify.*
    b. *Do the same for local commercial labs and Veterans Affairs hospitals.*
    c. *For each academic center, obtain list serves from the department chairs or other administrators.*
    d. *For all training programs, recruit the program directors as primary contacts for the entire training program. Because of yearly turnover, the NCD chose to exclude trainees as direct contacts in the Network.*
    e. *Contact all other pathologists on the master list for whom you possess contact information.*
8. Inquire whether or not contacted pathologist prefers to be excluded from the list. If so, convey this information to the Network Leader who will remove the name from the master list.
7. For initial contact failures:
    a. Check CAP member directory.
    b. Conduct Internet searches of the pathologists' names; (doctor rating sites may have phone contact information including those of retirees.
    c. Make phone calls as necessary.
9. Delegates report back to the Network leader with a list and correct information of confirmed contacts.
10. Network Leader compiles final spreadsheet of Network contacts.

Note: the North Carolina Delegation planned to conclude the project in one month. It took six.

Procedure for Validation

1. Have each Delegate/Alternate Delegate send a test email to each contact. CC the Network Leader on the email.
2. (If for record keeping you want to include all the contacts in the test email you must protect privacy by placing all Network contacts in the "blind CC" field."
3. Instruct recipients to confirm receipt by replying to email (reply all to Delegate/Alternate Delegate and Network Leader.
4. Network Leader will tally responses by area and sum of areas: # responses/total recipients.

Note: *North Carolina identified 498 potential contacts of which they were able to finalize 293. The response rate ranged from 29-75% in the 8 regions. The overall response rate was 53%.*

Metrics to Assess Effectiveness

1. Response rates to request for replies.
2. Attendance at CAP House of Delegates
3. Number (percent) HOD membership and nominations for membership
4. Response rate to the HOD's annual solicitation for issues to bring to the CAP Board of Governors.

Note: North Carolina used other softer, but nevertheless valuable metrics. For instance, using the Network to announce their White Coat Wednesday (a day on which pathologists journey to the state capital for political advocacy) they had the best turnout to date.

Maintenance

The Network Leader must initiate periodic updates of contact information.

Related documents

1. Electronic data file to contain the continuously updated network contact list
2. Cover letter to be included for initial Network contacts

General advice and difficulties to anticipate:

- Contact lists, even those of the State Medical Board are often out of date and laden with errors.
- Email addresses were at time inaccurate or not included on source lists. Many listed e-mail addresses were ancillary and not used by that the pathologists: Beware of "___ @___ hospital.org").
- It will be difficult to include trainees in the network as they relocate frequently. This is a good job to delegate to program directors.
- There are more small operations out there than you think.
- Remember to check for VA Hospitals and commercial labs.
- Some larger groups and commercial labs may overlap your network regions.
- Pathologists employed in physician office labs may be difficult to locate. Remember to ask your practice contacts if they know of these individuals.
- An occasional practice may not be receptive (North Carolina had one). Try to find out why and bring that information to the HODSC. They may arrange follow up and attempt to reconstitute relations.

Topic: **HOD Action Group on CAP Laboratory Accreditation Program Advisory Group**

Chair: S. Robert Freedman, MD, FCAP

HOD Steering Committee Liaison: Martha R. Clarke, MD, FCAP

Members:

Cynthia Bowman, MD, FCAP
James Clark, MD, FCAP
Michelle Powers, MD, MBA, FCAP
Zhai Qihui, MD, FCAP
Amyn Rojiani, MD, FCAP
Kalish Sharma, MD, FCAP
John A. Smith, MD, PhD, FCAP
V.O. Speights, DO, FCAP
Vidya Sriram, MD, FCAP
Robert J. Tomec, MD, FCAP
Blazej Zbytek, MD, PhD, FCAP

Date: February 27, 2015

CHARGE

To provide member feedback on checklist requirements, improvements to existing programs, products and services, ideas for new products and services, and future program strategies. Members should be conversant in CAP Cancer Protocols in order to give feedback to the LAP Advisory Group.

DESCRIPTION

Changes to the checklist requirements for surgical pathology reports for specimens with cancer have been proposed. These changes relate to the use of the CAP Cancer Protocols and the synoptic reporting format. They would apply to all types of laboratories, including community hospitals, as well as academic medical centers. Among the changes is to make ANP.12385 (Synoptic Reporting) a Phase I requirement. The Checklist Committee seeks input from the LAP Advisory Group and House of Delegates Action Group on this and related, proposed changes.

LAP ADVISORY GROUP

The LAP Advisory Group is an informal group, made up of members and non-members from CAP-accredited laboratories. The group does not meet and there is no chair. The areas of interest or specialty have been identified for each person on the panel, and individuals are asked for input on their areas of interest or specialty.

ACTION GROUP ASSIGNMENT

The action group reviewed each named checklist standard (ANP.12385 Synoptic Reporting, ANP.12350 Cancer Protocols, ANP.1235X Report Completeness [proposed]) and evaluated it for clear and understandable language, scientific/medical accuracy, best practice, application in the "real world," and ability for inspectors to evaluate compliance with the requirement. The action group gave feedback on whether a requirement to self-audit pathology reports is a reasonable requirement and whether the use of synoptic reporting should be an accreditation requirement.

LAP RESPONSE

"The input that the HOD Action Group provided was used by the Checklist Committee and the Commission on Laboratory Accreditation to confirm and/or make recommendations on a few proposed edits to checklist requirements related to synoptic reporting for the 2015 edition. The feedback was used to both confirm that proposed language was clear and understandable and guide further refinements before the checklist requirements went to their next phase of review with the Checklist User Groups."

Topic: **HOD Action Group on Pathology Practice Guidances (PPGs)**

Chair: Matthew D. Carr, MD, FCAP

HOD Steering Committee Liaison: Emily Green, MD, FCAP

Members: Samer Z. Al-Quran, MD, FCAP
Richard N. Eisen, MD, FCAP
Thomas S. Haas, DO, FCAP
Humayun K. Islam, MD, FCAP
Teri A. Longacre, MD, FCAP
Rebecca A. Osgood, MD, FCAP
Nicole D. Riddle, MD, FCAP
Meenakshi Singh, MD, FCAP

Date: February 20, 2015

CHARGE

To provide member feedback on the readability and applicability including accuracy, appropriateness and potential impact to patients and pathology practice on the Center Committee's new product: Pathology Practice Guidances.

DESCRIPTION

This action group is responsible to review the Center Committee's Pathology Practice Guidances (PPGs) as indicated in the Charge. It will also determine if broader feedback is required from the full House of Delegates that may result in a meaningful impact on the final PPG.

PPG Topics	Tentative Submission Date to HOD AG
Appropriate Testing of Testosterone Levels in Adult Males	Q4 2014 – Completed
Blood Culture: Time-to-Incubation	December 2014-January 2015
Pathologic Evaluation of Total Mesorectal Excision Specimens: Recommendations for Improving Patient Care	Late Q1 2015
CSF Gram Stain: Time-to-Result	Q2 2015
Correct Reporting of Antimicrobial Susceptibility Testing – Basics to Advanced (CRE Reporting of A/S and P/T)	Q4 2015
Utility and Cost-Effectiveness of *h. pylori* Immunostains v. Special Stains (Note: Submitted by HOD in November 2013)	Pending

ACTION GROUP ASSIGNMENT

The action group reviewed the PPG *Appropriate Testing of Testosterone Levels in Adult Males* anonymously using an online survey. Feedback and comments were summarized and provided to the Center Committee.

CENTER RESPONSE

Elizabeth Wagar, MD, FCAP, Center Committee Chair, acknowledged the action group's work and input in her follow-up memorandum of November 12, 2014: "The Center thanks the HOD Action Group for piloting our targeted comment period on our first PPG: *Appropriate Testing of Testosterone Levels in Adult Males.* This level of review is what the Center Committee desired and we look forward to future assessments."

Attachment: November 12, 2014, Center Committee Memorandum

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Memorandum

To: Emily Green, MD
Action Group Liaison, Center/CAP House of Delegates

Matthew Carr, MD
Action Group Chair, Center/CAP House of Delegates

From: Elizabeth Wagar, MD, FCAP
Chair, Center Committee

Date: November 12, 2014

Subject: **Follow-Up: HOD AG Evaluation of Pilot Pathology Practice Guidance (PPG)**

The Center thanks the HOD Action Group for piloting our targeted comment period on our first PPG: *Appropriate Testing of Testosterone Levels in Adult Males*. This level of review is what the Center Committee desired and we look forward to future assessments. Below is a summary of comments and author responses.

HOD Comment	Authors' Response
The title can be misleading, as it could be inferred that the PPG is addressing appropriate clinical indications for testing rather than methodology. The key question and background are clear.	With respect to the suggestions/comments on the PPG, we think all of them are excellent and thank the HOD for their diligent review. All but two (the potential ambiguity of the title and the proposed discussion of validating free testosterone assays) are easy to implement. We understand the concern that the title might promise a bit more than we deliver directly. However, in the first paragraph of the Discussion, we do explicitly state that the reader can find "recommendations regarding whom to test and therapeutic options" in the Endocrine Society guidelines provided in reference 3. We think it's probably best to avoid adding a discussion of validating free testosterone calculations. It's not that it's not an important topic, but rather that it would complicate this document, which is really targeted to laboratories which, in all likelihood, will be referring such tests to reference laboratories. What I would indicate to the reviewer who posed the question is that my sense is that it's important to do more than simply validate the individual assays; one really should validate that one's calculated value agrees with the reference lab's calculated values – it's far from a trivial calculation.
It would be beneficial to include a discussion of the controversy surrounding validation of calculated free testosterone assays. I've heard experts say the calculated values need to be validated against equilibrium	
In the Intro. The sentence beginning with "for good reason,' reads a little weird. I get the point, but maybe it can be rewritten.	
I am not sure if suggesting edits is within our purview, but I suggest the following in the Discussion: 1) first paragraph, suggest ""treating physicians" instead of "clinicians". 2). in paragraph 3, suggest "therefore, testing for deficiency is best performed at this time." 3) in paragraph 5, suggest "performed" instead of "done". I think the document will read better with these changes.	
for this sentance "For testosterone levels close to the 280 ng/dL threshold, additional testing for free testosterone may provide clarification" do you mean levels less than 280 but over 200 on 2 measurments? Maybe this is intentionally vague? leaving the ability to get additional testing in some scenarios outside of this range?	

Upcoming PPGs
Below is a list of the upcoming topics and projected date of submission to HOD AG:

PPG Topic	Tentative Submission Date to HOD AG
Blood Culture: Time-to-Incubation	Dec 2014-Jan 2015
Pathologic Evaluation of Total Mesorectal Excision Specimens: Recommendations for Improving Patient Care	Late Q1 2015
CSF Gram Stain: Time-to-Result	Q2 2015
Correct Reporting of Antimicrobial Susceptibility Testing – Basics to Advanced (CRE Reporting of A/S and P/T)	Q4 2015
Utility and Cost-Effectiveness of *H. pylori* Immunostains vs. Special Stains *(Note: Submitted by HOD in Nov 2013)*	Pending

As a reminder, the Center will provide a bi-annual summary report of the impact of HOD Action Group on the topics and PPGs overall. In addition, in Q4 2015 the Center will submit a survey to all HOD members on the overall value of PPGs alone and as compared to our evidence-based guidelines (EBGs).

Thank you for your support and leadership.

Sincerely,

Elizabeth Wagar, MD, FCAP
Chair, CAP Center Committee

Cc: Lisa Fatheree
Marci Zerante

Topic: **HOD Action Group on Rules III**

Chair: Nicole D. Riddle, MD, FCAP

HOD Steering Committee Liaison: Sang Wu, MD, FCAP

Members: Sharon Bihlmeyer, MD, FCAP
Avneesh Gupta, MD, FCAP
Ronald N. Horowitz, MD, FCAP
Augusto F. Paulino, MD, FCAP
Amyn M. Rojiani, MD, FCAP
Assad J. Saad, MD, FCAP
Gene P. Siegal, MD, PhD, FCAP
Vidya Sriram, MD, FCAP
Susan M. Strate, MD, FCAP

Date: February 20, 2015

CHARGE

- To provide member feedback on the HOD Rules to determine what changes are needed to ensure that the Rules are current, accurately describe the functions of the HOD and its members, are fair and appropriate, and structure House activities to best advance the mission of the College.

DESCRIPTION

The Action Group is asked to focus its review on HOD Steering Committee nominations and elections, apportionment, and how to bring open discussions to the House.

ACTION GROUP PROGRESS

The Action Group holds periodic conference calls. During its two conference calls, one in December 2014 and one in February 2015, the Action Group discussed enhancements to the nominations process, HODSC elections process, annual state apportionment, and open discussions during the House of Delegates meetings.

The Action Group intends to provide its recommendations to the HOD Steering Committee for the Fall 2015 HOD Meeting.

Topic: **Report of the Secretary Treasurer**

To: House of Delegates

From: Paul N. Valenstein, MD, FCAP, Secretary-Treasurer
Stephen R. Myers, Chief Financial & Operating Officer

Date: February 24, 2015

The following is a recap of financial results of the College for the fiscal years ended December 31, 2014 and 2013. Please note that the 2014 results, as presented, are unaudited. We do not anticipate any adjustments to these preliminary results, but they are subject to change based on the results of our annual audit.

Revenue

Revenue for Fiscal 2014 of $176.6 million increased by $8.4 million, or 5.0%, over the prior year. The College had strong revenue increases in the Proficiency Testing (PT) and Laboratory Accreditation Program (LAP) product offerings netted against a decrease in structured data revenue from discontinuing STS consulting services. The 2014 budgeted revenue was achieved. Overall, the College fared well in a tough economy.

Cost of Materials and Onsite Inspection

Cost of materials and onsite inspections for the year increased by $3.2 million in 2014 versus 2013. Cost of materials related to PT increased over the prior year in rough proportion to the increase in revenue, while the cost of onsite inspections for LAP rose slightly over the prior year. A concerted effort is made to control travel costs. As a percentage of revenue, cost of sales of 35.3% in 2014 increased from the prior year actual of 35.2%, with the majority of the increase coming from Proficiency Testing materials and packaging costs.

Operating Expenses and Capital Investment

Total CAP Expenses of $139.7 million for Fiscal 2014 were $8.8 million higher than Fiscal 2013. CAP continues the long-term investment in the College and the membership. The only project spending was on Enterprise Platform Program (EPP) to enhance the computer systems.

The most significant spending continues to be in the areas personnel and benefits and outside consulting. The increase in the personnel and benefits year over year was in line with the budget. Outside consulting increased from the prior year primarily due to higher investment in the EPP project.

Excess Revenue Over Expenses from operations was better than budget. The long-term investment portfolio decreased slightly due to increase spending on outside consultants on the EPP project. Overall, the financial performance for the year was good.

As in prior years, audited financial statements will be presented to the Finance Committee at their March meeting and at the May Board meeting. The House of Delegates will receive the audited financial statements at the annual meeting.

Topic: **Council on Accreditation Report**

To: Board of Governors

From: Richard R. Gomez, MD, FCAP, Chair, Council on Accreditation
Marcia B. Geotsalitis, MBA, Senior Vice President, Laboratory Improvement Programs

Date: November 10, 2014

1. Council on Accreditation ACTIONS Taken on October 24-25, 2014

Action	Action Taken	Staff Responsible
1. **AFFIRM** the current policy requiring that the entire laboratory submit to a complete inspection with exceptions made based on circumstances.	AFFIRMED	Denise Driscoll

2. COUNCIL/COMMITTEE PROGRESS ON INITIATIVES/ACTIVITIES

Laboratory Improvement Programs (LIP) Strategy

OPEN Priorities – LIP Strategy		Three Strategic Actions
1.1.1	Retain and Grow Domestic LIP Revenue Profitably	Stabilize and Strengthen the Core
1.1.2	Expand Internationally	
1.2.1	Manage Cost of Goods Sold	
1.2.2	Manage Operating Expenses	
1.4.1	Increase Our Focus on Relationships with Key Customers	
1.4.2	Improve the Customer Experience (NPS)	
3.1.1	Evolve Current Product and Service Features, Function and Value to Increase Competitiveness	Innovate from the Core
3.1.2	Accelerate the Development of Complementary Offerings	
3.2.1	Improve Process Efficiency and Effectiveness	Develop Delivery and Support Capabilities
Support Advancement of the Specialty		

LIP Strategy Recent Accomplishments:

We continue to make strong progress within our initiatives. Recent updates include:

- Inspection process/workforce model
  - Staff completed a market survey of laboratory accreditation customers and inspectors
  - Work is in progress to analyze survey results with the Inspection Process Committee and develop recommended options for in-depth analysis and testing.

Theme 1: Sustain Growth & Improve Profitability

Goal 1.1 Grow Revenue Profitably

Subgoal 1.1.1 Retain and Grow Domestic LIP Revenue Profitably

- CAP15189 has 80 participating laboratories with 39 accredited.
- CAP15189 has 60 laboratories in the pipeline with 5 international.
- Biorepository Accreditation Program (BAP) has 51 participating facilities with 28 accredited.
- Reproductive Laboratory Accreditation Program has 341 participating laboratories with 331 accredited.
- Forensic Drug Testing Program has 43 participating laboratories with 39 accredited.
- Laboratory Accreditation Program has 7,552 participating laboratories with 7,334 accredited.

Subgoal 1.1.2 Expand Internationally

- CAP International has 404 participating laboratories with 374 accredited.

Theme 3: Operate Efficiently & Effectively

Goal 3.1 Optimize Product Management Processes

Subgoal 3.1.1 Evolve Current Product and Service Features, Functionality, and Value to Increase Competitiveness

Subgoal 3.1.2 Accelerate the Development of Complementary Offerings on Existing Portfolio

Subgoal 3.1.3 Proactively Manage the Product Portfolio

- The Inspection Process Committee and the Commission on Laboratory Accreditation, under the direction of the council, have developed a process for approving new proposals to require specialty inspectors for the inspection of a laboratory specialty. In addition, the committee and commission developed a process for approving proposals for new and modified qualifications for those specialty inspectors. The new process will ensure that specialty inspector requirements are appropriate with respect to the needs and constraints of the accreditation programs.
- The Next Generation Sequencing (NGS) project team has requested that specialty inspectors be utilized for NGS inspections. This request will be evaluated in accordance with the new process for approving proposals to require specialty inspectors for the inspection of a laboratory specialty.
- The council will direct the Checklist Committee to draft an accreditation checklist item to require that bioinformatics laboratories that utilize a data center

must ensure that the facility meets all applicable requirements.

3. LIST OF DISCUSSION TOPICS

- The council discussed the New York State Department of Health Wadsworth Center's interest in pursuing acceptance of the CAP's PT program and, in addition, its desire for CAP to accept the Wadsworth PT program as a CAP-approved PT provider. The Accreditation Committee is working on a policy to address situations in which the CAP cannot send an inspection team to an international laboratory to perform an onsite inspection due to unsafe conditions for both US-based and local teams. A finalized draft of the policy and revisions to existing policies will be submitted to the council for approval at a future meeting.
- The Accreditation Education Committee (AEC) has been focusing on development of its Compliance Webinar Series, which will feature complimentary registration for CAP-accredited laboratories and the availability of post-session recorded sessions on the CAP website behind eLab Solutions.
- The AEC is developing a process to ensure any live training offerings will be appropriate to the needs of the audience (i.e. laboratory staff preparing for inspection versus inspectors).
- The Biorepository Accreditation Program Committee is interested in creating biobanking protocols and incorporating the information as resources to pathologists. The Cancer protocol for breast tissue currently contains information for collection of biospecimens for research. The Cancer Committee will be contacted to introduce the concept.
- The CAP15189 committee piloted a financial model for calculating returns on quality investments. The committee applied model with a client project and presented the results at the ASCLS Advanced Management Institute in July 2014 and Lab Quality Confab in October 2014.
- The CAP15189 committee has transitioned the first phase of customers to the ISO 15189:2012 version.
- Under the charge of the CLA, the Checklist Committee (CLC) reviewed and drafted revisions to the synoptic reporting requirements with both best practices and practical considerations in view. The CLC will recommend that the CLA approve its revisions to the synoptic reporting requirements developed by the Cancer Committee.
- The CLC is undertaking two separate projects to bring consistency and incorporate standardized language into the checklists:
    - Quality Terminology. The Checklists were reviewed for the use of five quality terminology terms. The review is complete and resulted in revisions to approximately 50% of the requirements. The changes are planned for the 2015 Checklist Edition.
    - Evidence of Compliance (EoC). The EoC checklist fragment is inconsistently applied, as some of the elements are required while others are simply an example. The CLC will review all EoC fragments and identify those that are required vs. examples.

- The Complaints and Investigation Committee will form a workgroup comprised of members and staff to evaluate the recommendations received from all of the CoA/CLA committees to determine the best focus areas to decrease the CAP's disparity rate for CMS validations.
- The CCC discussed options to provide comments that dispute the value in the CLIA 6-month mandatory cease testing requirement (i.e., impact on patient care) and steps that could be taken if the mandate is implemented.
- The CCC will schedule a meeting with CAP Surveys leadership to discuss the timeline for intervention on missing clerical information and alternate grading mechanisms when challenges are submitted with clerical omissions that result in automatic failure.
- The Inspection Process Committee discussed the results of the 2013 CMS External Validation findings and commented on proposed program improvements that should be further evaluated as possible mitigation strategies.

Topic: **Council on Education Report**

To: Board of Governors

From: Michael Prystowsky, MD, PhD, FCAP
Chair, Council on Education

Ann Neumann, PhD
Vice President, CAP Learning

Date: December 31, 2014

1. Council on Education ACTIONS Taken on DECEMBER 12-13, 2014

Action	Action Taken	Staff Responsible
1. Provided input on the learning strategy execution plan and initial analysis of the 2013 learning portfolio.	**Provided Input**	Ann Neumann
2. Approved the *Creating a Culture of Patient Safety* proposal, a course designed to meet ABP's MOC patient safety requirement.	**Approved**	Loretta Morrison
3. Did not approve the *LMD for Residents* proposal.	**Disapproved**	Loretta Morrison
4. Approved recommended changes to the GMEC charge.	**Approved**	Ann Neumann
5. Provided input on the CGPA's communication strategy.	**Provided Input**	Ann Neumann
6. Provided input on collaboration opportunities between the COE and HOD.	**Provided Input**	Ann Neumann
7. Provided input on the evolutionary opportunities identified by the Curriculum Committee for the CAP '15 education program.	**Provided Input**	Kim Kruger
8. Agreed on response to a USFNA participant appeal of assessment results.	**Agreed**	Rebecca Fulcer
9. Provided input on the 2015 CAP Learning Marketing Strategy.	**Provided Input**	Kathy Fox
10. Agreed with the Curriculum Committee's recommendation to discontinue the CAP Companion Society Session at the ASCP Annual Meeting.	**Agreed**	Kim Kruger

2. COUNCIL/COMMITTEE PROGRESS ON INITIATIVES/ACTIVITIES COUNCIL/COMMITTEE PROGRESS ON INITIATIVES/ACTIVITIES

Theme 2. Advance the Specialty

GOAL 2.1 Drive Member Loyalty

Sub-Goal 2.1.2 Improve Member Experience (NPS)

Learning Management System (LMS) Replacement Project Update

The launch date for the new learning management system is planned for early 2015. Currently, the project team is preparing to start user acceptance testing and focused on migrating historical data to the new system.

GOAL 2.2 Prepare Pathologists for Future Roles

Sub-Goal 2.2.1 Provide Tools, Education and Resources

Learning Opportunities for Enhanced Services

The purpose of Initiative 12 is to develop CME learning opportunities in Informatics and Genomics to better equip practicing pathologists to provide enhanced services. The focus in 2013 was on curriculum planning and 2014-15 focused on education development and delivery. In 2014, the Genomics Education Working Group planned and delivered four genomics webinars, and DIHIT members delivered two informatics webinars and initiated development of two online courses. 2015 plans include four new genomics and two new informatics webinars, along with release of two informatics courses.

Sub-Goal 2.2.2 Ensure Pathology Graduate Medical Education Meets the Needs of the New Models

Graduate Medical Education Clinical Informatics Curriculum

In collaboration with APC and API, CAP launched Pathology Informatics Essentials for Residents (PIER) on September 30. PIER presents training topics, implementation strategies and resource options for PRODS and faculty to effectively provide informatics training to their residents and meet ACGME informatics milestone requirements. Representatives of 14 PIER Alpha Test programs participated in a training webinar last month; data collection will take place between December 2014 and December 2015. Release 1 is available on the APC website (http://www.apcprods.org/pier/) for use by all residency programs during alpha testing.

GOAL 2.3 Strengthen the Practice of Pathology

Sub-Goal 2.3.1 Offer Market Driven Learning Opportunities that Maximize Competence

CAP ’15 Planning Update

The Curriculum Committee finalized the CAP’15 education program in November. The program includes nearly a hundred courses across a broad menu of Anatomic and Clinical Pathology and Practice Management topics, with more in-depth offerings in high priority learning areas (e.g., Breast, GI, molecular oncology, clinical informatics). Faculty confirmations are well underway. The committee also reviewed the results of the Annual Meeting Opportunity Survey (AMOS). They agreed to implement small evolutionary improvements that align with the broad results of AMOS and the current approach to continually improve the Annual Meeting learning experience.

Advanced Practical Pathology Programs (AP^3)

The CAP hosted four AP^3 workshops this fall. The following table displays final registration and key evaluation results.

AP3 Registration and Key Evaluation Results

AP^3 Program	Date & Location	Final Registration	Overall Value Rating	% Recommending Program to Colleague
Laboratory Medical Director (LMD)	Oct. 2-3 Chicago, IL	18	5.00	100%
Multidisciplinary Breast Pathology (MBP)	Oct. 25-26 Chicago, IL	32	4.74	96%
Prostate	Nov. 7-8 Chicago, IL	15	4.93	100%
Ultrasound-Guided Fine Needle Aspiration (USFNA)	Oct. 18-19 Atlanta, GA	18	5.00	N/A*

* Question not asked on the USFNA Evaluation Form.

Theme 3. Operate Effectively and Efficiently

GOAL 3.1 Optimize Product Management Processes

Sub-Goal 3.1.3 Proactively Manage the Product Portfolio

Learning Strategy Refresh Execution

Since August, CAP Learning and Member Marketing staff developed a plan to guide strategy execution activities. The plan includes four concurrent work streams focused on 1) portfolio enhancements, 2) marketing enhancements, 3) capability enhancements, and 4) change management. Work is underway, with several activities on target to be complete by the end of year. A major focus for Q1 and Q2 of 2015 will be conducting an updated learning needs assessment survey and using results to inform portfolio goal setting to ensure alignment with the refreshed strategy as well as inform marketing activities to better target selected

market segments.

GOAL 3.3 Evolve Our Culture

Sub-Goal 3.3.3 Attract, Develop & Retain the Right Talent

Employee Survey Action Plan Implementation

In 2014, CAP Learning focused on implementing action plans addressing key areas identified for improvement based on results from the 2013 Employee Survey. Activities included development of professional development FAQs for the team, identification of key capabilities required for CAP Learning to implement the learning strategy and achieve its business objectives, and identification of top division learning needs aligned with the key capabilities. Additionally, the division began implementing a quarterly professional development forum designed to address critical learning needs for the division. Finally, CAP Learning initiated the use of the RAPID decision-making process in order to improve the division's decision-making capability.

3. LIST OF DISCUSSION TOPICS

- Learning Strategy Refresh – Review the approved strategy, overview of the execution plan and early results of the current portfolio analysis
- Learning Portfolio Subcommittee (LPSC) Update – Obtain approval of the LPSC recommendations for two new learning activity proposals (Creating a Culture of Patient Safety and LMD for Residents) and provide updates on other LPSC activities
- GMEC Charge – Obtain approval of the GMEC's recommended changes to its charge
- Learning Management System (LMS) Update - Provide an update on the LMS replacement project
- CAP Enterprise Alliance Strategy Update – Share update on the CAP Enterprise Alliance activities
- Advocacy Update – Share update on CGPA's charge and current priorities
- House of Delegates (HOD) Update – Share update on the HOD's charge and discuss ways the HOD can help further COE goals
- Annual Meeting Opportunities Research Results, Recommendations and Next Steps – Share and discuss research results and recap Curriculum Committee plans for CAP '15
- CAP Brand Strategy – Provide an update on member brand engagement activities at CAP '14 and plans for the January 2015 external launch of the new logo
- Initiative 12 Update – Share update on the 2014-15 curriculum
- 2015 CAP Learning Marketing Strategy Overview – Provide an overview of the 2015 marketing strategy and Q1 2015 marketing tactics

Topic: **Council on Government and Professional Affairs Report**

To: Board of Governors

From: George F. Kwass, MD, FCAP, Chair
John H. Scott, Vice President, Policy and Advocacy

Date: November 10, 2014

1. Council on Government and Professional Affairs ACTIONS taken on November 1-2, 2014

Action	Action Taken	Staff Responsible
APPROVE CGPA recommendations on the 2015 measure development strategy and continued maintenance of CAP-developed measures, development of new measures, and allow for clinical practice improvement activities as PQRS alternative	AGREED with proposed plan	Fay Shamanski, MD
APPROVE adoption of a revised model for reviewing coverage policies to improve the effectiveness of CAP's engagements with local Medicare contractors on coverage policies.	AGREED with proposed plan	Jennifer Madsen
APPROVE issue prioritization framework and strategies for aligning the FDA guidance with CAP policy positions **and** review high-priority issues and identify potential modifications to the FDA LDT regulatory framework.	AGREED with proposed plan Recommend for Board Action	Helena Duncan
APPROVE near term federal legislative priorities and a renewed focus on PQRS to ensure members can comply with future programs and seeking opportunities for self-referral when they arise as an SGR payment reform "pay for".	AGREED with proposed plan	Michael Giuliani
APPROVE 3-5 year priority state legislative issues, including efforts to implement direct billing, ACO Model State Legislation, balance billing and network adequacy and self-referral	AGREED with proposed plan	Barry Ziman
REJECTED proposal to add nurse scope of practice to state advocacy agenda	DISAGREED with proposed plan	Barry Ziman

Action	Action Taken	Staff Responsible
APPROVE with plans to release the 2014 Practice Characteristics Survey in November 2014	AGREED with proposed plan	David Gross
APPROVE Advocacy communications STATLINE modifications to shift the publication day for Statline to every Tuesday rather than Thursday and to move the publication to a weekly schedule	AGREED with proposed plan	Laura Diamond

2. COUNCIL/COMMITTEE PROGRESS ON INITIATIVES/ACTIVITIES/DISCUSSION

Theme 2: Advance the Specialty

Goal 2.4 Influence Public Policy to Sustain and Advance the Specialty

Subgoal 2.4.1 Advocate for Favorable Payment and Regulatory Policies

Mitigate Payment Cuts

Discussed and evaluated strategies for influencing pathology payment rates in the 2015 Medicare Physician Fee Schedule Final Rule, and communicating with CAP members about the impact of CAP's advocacy.

Pay-for-Performance

CGPA approved the EAC 2015 plan on PQRS. The EAC 2015 plan is to work to extend the life of CAP's existing measures for as long as possible given that the majority of CAP Members use these measures to comply with PQRS. CGPA also approved plan to elevate needed PQRS legislative relief as the top legislative priority going into 2015. EAC will continue to evaluate the registry option and make a recommendation in 2015.

Palmetto/Local Coverage Determinations

CGPA approved the staff plan for responding to the Palmetto LCD postings. CGPA is working closely with CSA on developing its response. In addition, CGPA approved in concept a CGPA-CSA initiative to strengthen LCD response that involves establishing a standing LCD response group made up of members from both Councils.

Laboratory Developed Tests (LDTs)

CGPA endorsed the staff recommendation on positioning and declined to sign-on to an AMA/ACLA letter calling on the FDA to withdraw its draft guidance document and reissue it as a regulation. AMA has set a deadline for signing on to the letter by November 14th. CAP has reviewed the FDA LDT Guidance and declined to sign-on to the AMA letter, and affirmed CAP positioning. Changes will be needed and CAP's ultimate support for the FDA Guidance is contingent upon whether CAP believes FDA makes necessary changes. Staff is working on talking points for use by CAP Leadership as our position begins to take hold.

Near-Term Federal Legislative Priorities

CGPA supported a Federal and State Affairs Committee recommendation for an adjustment to our near-term legislative strategy over the next 6 months. The strategy targets specific legislative asks at what will most likely be an 18th "patch" to prevent reimbursement cuts under the Sustainable Growth Rate (SGR). On self-referral, we are continuing to advocate for closing the IOAS exception by taking advantage of opportunities that arise legislatively and focus on using the savings generated as a "pay for" for SGR reform.

Refreshing our State Affairs Agenda

Direct billing has been a successful campaign for many years and there's a need for feedback to guide ongoing efforts. In Ohio, we will be focusing on direct billing and anti-mark-up. CGPA also supported advocacy in support of ACO legislation at the state level. Self-referral advocacy efforts are also underway at the state level. CGPA approved a new state issue in the form of ensuring network adequacy and balance billing.

Nurse Scope of Practice

By a vote of 12-2, the CGPA rejected the proposed nurse scope of practice advocacy policy and removed this as a priority state legislative issue.

Subgoal 2.4.2 Conduct socioeconomic research to inform CAP's Public Policy Agenda

Field and Publish the 2014 PC Survey Report

The Board has already received—or will soon be receiving—an Information Report that includes a draft of the 2014 Practice Characteristics Survey. This draft, which was prepared by a Policy Roundtable-led Project Team, was approved at the November 1-2 CGMA meeting. Assuming there are no objections from the Board, we anticipate releasing the report shortly after Thanksgiving. The release strategy will be coordinated with Communications and Marketing.

Develop a 2015 Practice Leader (HOG) Survey

PRT is developing a new Practice Leader (PL) Survey, which we hope to field Q1 or Q2 of 2015. The purpose of the survey will be to provide practice level data on areas such as payer mix, sources of income, types of patients, infrastructure and data access, and market and regulatory trends affecting the practice—information that the typical pathologist-in-group would not know. The survey should allow us to track trends over time and to analyze data vary by type of setting, type of practice, practice size, and other key variables. We will be coordinating this work with EAC, Practice Management, and Member Research.

Subgoal 2.2.2 Ensure Pathology Graduate Medical Education Meets the Needs of the New Models

Field New-in-Practice Survey

The PRT-led survey of new-in-practice pathologists is being fielded November 1-January 31 in conjunction with the ABP's Maintenance of Certification Exam. This effort, a direct outgrowth of last December's Pathology Workforce Summit, was developed in collaboration with APC, ASCP, ABP, ACGME, and PRODS.

Subgoal 2.4.3 Organize and Mobilize CAP Members for Policy Action

Strengthen PathNET

We have successfully identified grassroots champions for 8 of the 12 key members of Congress we are targeting this year and developed relationship maps to strengthen our advocacy efforts with all 140 Congressional targets. Social media tools have been integrated into the PathNET platform, though they have only been used by 19 CAP members thus far. We also discussed the introduction of new training resources on the CAP website, including short, informative videos now available on the CAP website and plans for a webinar early next year. At the state level, the Council reviewed our progress in utilizing PathNET as an advocacy tool on state issues and was briefed on the efforts to make the quarterly conference calls with state issue advisors more effective in receiving feedback on activities in the states.

Strengthen PathPAC

It is unlikely that the CAP will meet the goal of raising $300,000 for PathPAC and $50,000 for the PEF this year. PathPAC has sponsored 3 in-district fundraisers with CAP members and increased participation by CAP members at in-district fundraising events 12. In addition, we are in discussion with several grassroots/PAC vendors regarding new software options to improve online giving, data collection and analysis, as well as providing the ability to accept monthly online donations.

Theme 3: Operate Efficiently and Effectively

Goal 3.2 Strengthen Operations and Improve Execution

Subgoal 3.2.3 Ensure Consistent and Clear Communication

STATLINE

Effective January 2015, advocacy communications staff received CGPA approval on increasing the production of STATLINE from a bi-weekly to a weekly news source for CAP members, moving the STATLINE publication day from Thursday to Tuesday, and featuring regular monthly columns dedicated to Policy and Advocacy's regulatory and legislative efforts. Further, advocacy communications gave a high-level overview of a five-week digital advertising campaign targeting policy influencers in Washington, DC

Topic: **Council on Membership and Professional Development January 2015 Report**

To: Board of Governors

From: Bharati Suketu Jhaveri MD, FCAP, Chair, Council on Membership and Professional Development
Maryrose Murphy, Vice President, Membership and Professional Development

Date: February 9, 2015

1. COUNCIL ON MEMBERSHIP AND PROFESSIONAL DEVELOPMENT ACTIONS TAKEN ON JANUARY 24-25, 2015

Action	Action Taken	Staff Responsible
1. APPROVED a plan to redesign the Engaged Leadership Academy (ELA) for 2015 that includes: • Maintaining the two day immersion experience • Changing the venue from a downtown hotel to a location near the airport • Charging a registration fee per participant • A participant application process involving the Community and Professional Engagement Committee	APPROVED	Maryrose Murphy Marci Zerante Michael Phipps
2. APPROVED establishing a task force to review the CAP Mailing List Policy to determine current best practices, and to include sharing member information with the State Delegate Chairs.	APPROVED	Maryrose Murphy
3. APPROVED the following 2015 goals for the Council on Membership and Professional Development: • Develop recommendations on how the CAP can work with state pathology societies for mutual benefit • Sustain and improve the CAP Annual Meeting including recommendations for a long term strategy (e.g. 2020) • Continue to focus on increasing membership in the 1-10 years in practice segment • Focus on ways to inform members of existing CAP resources developed by pathologists for pathologists	APPROVED	Maryrose Murphy Doug Knapman Marci Zerante

Action	Action Taken	Staff Responsible
4. **AGREED** with the recommendation to establish an Annual Meeting Ad-Hoc Committee being considered by the Board of Governors Executive Committee on January 31 – February 1, 2015.	AGREED with the recommendation	Maryrose Murphy
5. **AGREED** with the proposed questions included in the Member-Staff Partnership Report.	AGREED with proposed plan	Maryrose Murphy
6. **AGREED** to a cluster format for one council/committee meeting event in January 2016.	AGREED	Maryrose Murphy

2. COUNCIL/COMMITTEE PROGRESS ON INITIATIVES/ACTIVITIES

Results for 2014 separately conveyed.

3. LIST OF DISCUSSION TOPICS

- Conflicts of Interest, PRIDE Principles, Enterprise Strategy, OPEN to align current and new members on these topics
- Committee Charges and Goals – Encouraged committee's to review and update their current charges and set goals for 2015.
- Engaged Leadership Academy (ELA) – Received results of 2014 ELA; Reviewed proposed options, approving option with additional direction
- CAP Mailing List Policy – For review, update and expansion as appropriate.
- CAP Annual Meeting – To examine ways to sustain and improve the meeting.
- Member-Staff Conversation Questions – Review and approve set of recommended questions for the CMPD committees to include in their 2015 meetings and report back to the CMPD.
- State Pathology Societies Advisory Group – Received a status update on how this group has started its work.
- Membership Metrics – To determine the type and format to follow longitudinal metrics.
- 2015 Proposed Goals for each member group – Chairs shared their proposed 2015 goals to facilitate collaboration, alignment, and receive input from the Council
- Future Meetings – To determine the most efficient and economical ways for the council and its committees to meet and accomplish their goals.
- Member Communications – To determine ways to inform members of existing CAP resources developed by pathologists for pathologists.

COLLEGE of AMERICAN PATHOLOGISTS

Information

Topic: **Council on Scientific Affairs Report for the CAP House of Delegates**

To: Board of Governors

From: R. Bruce Williams, MD, FCAP, Chair, Council on Scientific Affairs

Date: March 2, 2015

COUNCIL/COMMITTEE PROGRESS ON INITIATIVES/ACTIVITIES

Theme 1: Sustain Growth & Improve Profitability

Goal 1.1 Grow Revenue

Subgoal 1.1.1 Maximize Traditional Revenue Sources

STEP (Structured Evaluation Process)

- StEP new product revenue was very strong in 2015. Twenty one clinical pathology new products were introduced. Leading the charge is the next generation sequencing (NGS) product which currently has 186 participants.
- A series of 11 new StEP products for second instrument reporting was initiated in 2015 to meet customer needs in response to changing Centers for Medicare and Medicaid Services regulations.
- For 2016, there are currently 29 new StEP products being developed for potential implementation. The StEP teams will continue to develop, refine and advance these product concepts over the next few months.

Theme 2: Advance the Specialty

GOAL 2.1 Drive Member Loyalty

Subgoal 2.1.1 Empower Member Interaction, Collaboration and Knowledge Sharing (Engagement)

CSA Leadership Meeting

At its February 2015 CSA Leadership Meeting, general presentations and breakout sessions were conducted on the topics of in vivo microscopy, clinical informatics, CAP Learning, CAP Accreditation, House of Delegates collaborations, StEP, marketing, and new product development. This event was co-located with the Council on Education and a number of shared sessions were held.

GOAL 2.2 Strengthen the Practice of Pathology

Subgoal 2.3.2 Support Efforts to Strengthen the Field of Pathology and Laboratory Medicine

Test Ordering Project Team

The CSA has been working to develop questions regarding test ordering practices. The CSA's Test Ordering Project Team, in cooperation with the Strategy and Advocacy areas of the College, are writing the questions. The team is considering the target audience for the questions and envisions a sizable representation of laboratory directors.

Expert Opinion Statements
The Center Committee and CSA are recommending to the Board of Governors that non-evidence based guidelines no longer be developed by the Center. Instead, a recommendation is going forth that expert opinion statements be developed under the banner of the CSA and the Council on Education as a cooperative initiative. Envisioned in this process is a strong collaboration with the Council on Government and Professional Affairs, the Council on Membership and Professional Affairs and other member groups of the College, such as the House of Delegates, as appropriate. The CSA hopes to report back with substantive advancement of this concept by the next House Meeting.

Candidate Forum 2015

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Secretary-Treasurer

- Candidate Profile: Richard R. Gomez, MD, FCAP
- Candidate Profile: George F. Kwass, MD, FCAP
- Candidate Profile: Gail Habegger Vance, MD, FCAP

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- Candidate Profile: Edward P. Fody, MD, FCAP
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- Candidate Profile: Frank R. Rudy, MD, FCAP

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for President-Elect

R. Bruce Williams, MD, FCAP

The Delta Pathology Group, LLC
Shreveport, Louisiana

Age: 65
Years in Practice: 36
Boards: AP/CP
Education: Received MD, 1975, Vanderbilt Medical School, Nashville, Tennessee; Internship: Vanderbilt Medical School; Residency: Vanderbilt Medical School, Nashville, Tennessee and Louisiana State University School of Medicine, Shreveport, Louisiana

Employment Status: Full Time
Practice Type: Hospital/Community Based Laboratory
Practice Size: 31 or more

CAP Experience:

2009-present	Governor
2010-present	Member, Executive Committee
2011-present	Chair, Compensation Committee
2009-2011	Member, Compensation Committee
2009-present	Member, Finance Committee
2011-present	Vice Chair, Investment Committee
2009-2010	Member, Investment Committee
2009-2013	Member, Audit Committee
2010-2013	Member, Risk Management Committee
2010-2011	Member, Strategy Management Committee
2011-present	Chair, Council on Scientific Affairs
2010-2011	Chair, Council on Membership and Professional Development
2009-2010	Vice Chair, Council on Membership and Professional Development
2007-2009	Chair, Council on Accreditation
2005-2006 & 2012-2013	Member, Council on Accreditation
2005-2009	Chair, Commission on Laboratory Accreditation
1990-2005	Member, Commission on Laboratory Accreditation
2008	Chair, Ad Hoc Committee on Gynecologic Cytopathology Monitoring
2008-2009	Member, Ad Hoc Committee for Center Plan Development
2007	Chair, CAP Nominating Committee
2006	Member, CAP Nominating Committee
2006-2009	Member, Ad Hoc Committee on New Technology

Experience in Other Organizations:
I have served in various capacities in the Louisiana State Medical Society, including Member (1977-present) Vice Speaker (1987-1992), Speaker (1992-1996), President Elect (1996), President (1997), Immediate Past-President (1998); Board of Governors (1987-1998), and numerous standing and ad hoc committees

I have served in various capacities in the Shreveport Medical Society, including Member (1977-Present), Board of Directors (1986-1993), Treasurer (1987-1989), 2nd Vice President (1990), President Elect (1991), President (1992), Immediate Past-President (1993), Mediation Commission (1993-1994), Membership Committee (1991), Distinguished Service Award Committee (1993-1995), Public Relations Commission (1994-1995 & 2000), Program Commission (1994-1995), Advisory Commission (1994), Honor Award Committee (1992-Present), Media Committee, Ethics and Judicial Commission (2001-2014), Budget and Finance Committee (1993-2014), Articles and By-Laws Committee (1993-2014), Nominating Committee (Periodic), Parliamentarian (1987-2014), and SMS Golf Classic Committee (1999-2014).

I have served as an alternate delegate to the American Medical Association.

I have served in Willis Knighton Health System on the Executive Committee (1987-1990), Medical Staff President (1988-1989), Continuing Education Committee (1980-Present), and multiple standing and ad hoc committees.

I have served at Christus Schumpert Medical Center on a member of the Credentials Committee (2000-2014), Quality Management Council (2001), Institutional Review Board (2003-2006), Medical Executive Committee as Clinical Service Representative for Pathology (2006-2013).

I am currently a member of the Medical Executive Committee at Our Lady of Lourdes Regional Medical Center and at Heart Hospital of Lafayette (2013-Present).

I have served on the board of the Biomedical Research Foundation in Shreveport, LA. The purpose is to promote and develop technology-based activities and companies in northwest Louisiana.

Why do you want to be a governor or officer of the College?
For my entire career in the practice of Pathology, the College of American Pathologists has been an important and integral part of my professional practice. From the first year in practice when I helped prepare our laboratory for a CAP inspection, I recognized CAP was a special organization. Here was an organization that cared enough about the practice to do positive things to help all pathologists. Throughout my career, whether it was our onsite inspection, and the ability to go to another laboratory and see how they practiced; to publications that were useful, entertaining and informative; to educational activities; to representing Pathologists in Washington and in the states; to providing practice guidelines; to preparing us for the future, professionally and economically; to providing us with the materials for everyday practice, the College of American Pathologists is

indeed a special organization. While I have been fortunate enough to have participated in activities in the College during almost all of my professional life, I would like to continue my contribution to the profession by running for President-Elect of the College. I feel that my various activities and experiences in many different areas of the College have prepared me for this position. I feel that my six years on the Board of Governors has given me the more complete knowledge of how the College works in order to be able to lead the College through the coming times that face our profession. It would be a very great privilege to be able to help further the Practice of Pathology by being elected to the position of President-Elect and then President of the CAP.

How do you assess your contribution to the CAP Board of Governors during your current term of office?

I feel that I have made significant contributions to the CAP Board of Governors during my term in office. In addition to just attending Board and Executive Committee meetings, I feel that my input into discussions concerning the workings of the College have helped bring important viewpoints and information to the entire Board. I have served as Vice Chair of the Council on Membership and Professional Development (CMPD) for a year and thereafter served as Chair for a year. Then, during this current three-year term, I have served as Chair of the Council on Scientific Affairs (CSA). During my years on CMPD, we integrated the House of Delegates Speaker and Vice Speaker into our council and I was involved in helping the House integrate more closely into the workings of the College as a whole. During my three years as Chair of CSA, we have continued to introduce new proficiency testing (PT) products every year and continue to increase PT revenue for the College. We have worked diligently on planning and beginning to implement a new Laboratory Improvement Programs Strategy to strengthen our LAP and PT offerings. We have integrated many of the committees that were formed because of the transformation and which used to be under the Transformation Program Office Steering Committee into the CSA. Those transitions have gone smoothly, and many of these new committees are offering great new services to our members and to the College. We have worked more closely with the Council on Education to enhance the number of educational offerings and have piloted a fast track development of already written products into formal CME offerings. We have worked with the Council on Accreditation to develop new checklists and new checklist questions and to help with other accreditation issues. We have worked with Council on Government and Professional Affairs on issues affecting pathology by governmental agencies (such as CDC, CMS, FDA, etc) as well as Congress.

In addition to serving on the Board of Governors, I have served for four years on the Executive Committee of the Board. This is an opportunity to spend some additional time looking in depth at issues which face the College.

I also serve the Board by being on some Board committees. I have served on the Finance Committee, Investment Committee and Audit Committee, as well as being the Board member on the staff retirement committee, helping direct the expenditures of the College in a meaningful way

and to help guide our investments in the general investment fund as well as the retirement fund of the College.

What major issues do you see facing the College during the next three years?
There will be numerous issues facing the College in the next three years.

On the financial front, we must continue to defend our major market areas of Proficiency Testing and Accreditation. We have developed a Laboratory Improvement Programs Strategy, which strives to solidify our position as front runners in both fields as well as to expand those markets both domestically as well as internationally.

With the national health care changes that are occurring, the College must better prepare our members for the new playing fields present in the health care management and reimbursement areas. We have begun work in these areas, but we need to do more to help our members be successful in the new environment.

There are changes in Washington that we will have to address. There is the yearly CMS evaluation of CPT codes and the reimbursement rates for all fields, including pathology, that we have to defend and advance the importance of the role of pathology in the healthcare team. CMS has oversight of our accreditation program and the FDA is starting to get more involved in the laboratory with its Laboratory Developed Tests rules. The CAP will have to continue to work with federal agencies to make sure the regulations are sound and functional. We will have to work with agencies and Congress in many different fields, such as the in-office exemption for anatomic pathology labs.

One of our biggest internal challenges is to continue to implement or new IT system in an efficient and effective manner. There have been great strides made in the past years, but we must continue to implement the system in a matter that gives the most return for the investment. The new web site is the most recent visible example of the continuing IT strategy, but there have been great improvements made behind the scenes in recent years and there continues to be important areas of improvement needed in the coming years.

If elected, what do you hope to accomplish?
The College is so multi-dimensional that all that could be accomplished in the next four years is impossible to innumerate. This will be a very short synopsis of some of the areas in which I would like to concentrate.

The first thing is that I would like devote significant efforts to is to securing the financial foundation of the College so that it can continue to provide all of the essential diverse functions for the practice of pathology. Without a strong income stream, the College would not be able to function fully in all of its important areas. This effort would include continuing to secure our base income streams in PT and LAP both domestically and internationally. It would also include exploring new opportunities to produce positive net revenue to help support the practice of pathology.

Our members are the reason we exist. As previous Vice-Chair and Chair of CMPD, I understand the importance of the services, activities and programs we provide our members and the importance of member input into the activities of the College. In line with that, I would continue to elevate the activities of the House of Delegates to ensure that the Board and the rest of the College hear to voice of the membership.

My efforts would include continuing the excellence of as well as strengthening our two largest core efforts, the Laboratory Accreditation Program and our Proficiency Testing Programs, together known as the Laboratory Improvement Programs (LIP). We have outlined the first steps of an LIP strategy to further these programs. However, future components of the LIP will be developed and implemented. In addition, individual advances in both programs will be designed and instituted.

A large effort will continue to be made in the professional practices area with the advent of ACO and other value based payment activities. The efforts of Pathologist and their contribution to patient care must be recognized, elevated to others and payment made accordingly. Part of my efforts would be in this area, to help perverse and strengthen the practice of Pathology.

The College has made great strides in recent years to provide excellent educational activities, both online and by live courses. Self Assessment Modules (SAMs) are important to our members. I have strongly supported our educational efforts both as a Board member and as Chair of CSA. I would continue to support the educational activities of the College and to expand them economically.

Our legislative efforts and governmental affairs efforts are a touchstone of the College's efforts on behalf of its members and the practice of Pathology. I would strongly support continued efforts in Washington to make sure that pathologists are heard and that the CAP provides to regulators and Congress a sound scientific basis for actions proposed to be taken by government agencies and Congress.

The functioning of the College staff is the responsibility of the CEO. The Board of Governors has the responsibility to oversee his activities, all of which are vital to have a vibrant, effective and efficient staff. As President I would work with the CEO to ensure that the staff has the tools they need to function on behalf of members and customers and that important internal activities of and improvements in the College (such as the updating of our computer capacity and functions) proceeds with all due speed at a cost that is in line with value received.

As stated, these are just a few of the areas in which I will devote time and efforts in order to try to improve the function of the College and promote the activities of pathologists and the practice of pathology.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Secretary-Treasurer

Richard R. Gomez, MD, PhD, FCAP

St. Francis Health
Ozawkie, Kansas

Age: 61
Years in Practice: 24
Boards: AP/CP
Education: Received MD, 1985, Uniformed Services University of the Health Sciences, Bethesda, Maryland; Internship: William Beaumont Army Medical Center, El Paso, Texas (Transitional Internship); Residency: William Beaumont Army Medical Center; Fellowship: MD Anderson Cancer Center, Houston, Texas (Surgical Pathology)

Employment Status: Full Time
Practice Type: Hospital/Community Based Laboratory
Practice Size: 6-10

CAP Experience:

2010-present	Governor
2012-present	Liaison, CAP Foundation Board of Directors
2012-present	Chair, Council on Accreditation
2012-present	Member, Executive Committee
2013-present	Member, Compensation Committee
2011-present	Member, Finance Committee
2011-2012	Vice Chair, Council on Education
2011-2012	Member, International Venture Steering Committee
2010-2011	Vice Chair, Council on Membership and Professional Affairs
2008-2010	Chair, Federal and State Affairs Committee
2006-2007	Vice Chair, Federal and State Affairs Committee
2004-2005	Member, Federal and State Affairs Committee
2008-2011	Member, Council on Government and Professional Affairs
2008-2010	Member, Professional and Community Engagement Committee
2010-present	Advisor, Residents Forum
1989-1991	Delegate, Residents Forum

Experience in Other Organizations:
At St Francis Health, I have had the opportunity to serve on several committees, both as a committee member and committee chair. I have served as the Chair of Medical Record and Utilization Committee, Cancer Committee, and the Medical Executive Committee. I was

Medical Staff President from 2007 to 2009. As medical staff president, I served on the hospital Board of Directors.

Locally in the community, I served on the YMCA Board of Directors for 5 years, and the YMCA Foundation Board for 3 years. I participated in many fundraising campaigns during my voluntary service to the YMCA, as well as providing guidance to the YMCA Director and staff regarding financial resources.

I served as President of the Shawnee County Medical Society for two years. The County Medical Society was involved in educational programs for the physician members and in the development of a program called "Health Access". This program provided medical care at no cost to the uninsured individuals in need in Shawnee County.

At the state level, I have been involved in the Kansas Medical Society as a delegate (Shawnee County). I am currently the President of the Kansas Society of Pathologists. The KSP has provided educational opportunities to our members through live seminars on Cancer Biomarkers and through joint educational programs with the Kansas City Society of Pathologists.

Why do you want to be a governor or officer of the College?
I would like to continue my participation in CAP governance as an officer, and thus I am seeking the position of Secretary-Treasurer to represent our members in the stewardship of our vital resources.

The financial and human resources of the College support our vision and mission, and the ability to sustain and effectively manage these resources will enable us to provide our members with advocacy efforts, education, and practice tools as we meet the challenges ahead of us. The judicial use and management of our financial, member and professional staff resources are essential to our success. The Secretary-Treasurer works closely with senior staff leadership to develop and review the proposed annual budget, presenting it to the Finance Committee and Board for approval. The management of our policies is important as we move into the future, and as Secretary-Treasurer I will be responsible for ensuring these policies are reviewed/revised/ approved as appropriate by the Board of Governors. As I seek the position of Secretary-Treasurer, I am fortunate to have the support of my pathology group and family. This support will enable me to be engaged with the College and fulfill my obligations as an officer.

How do you assess your contribution to the CAP Board of Governors during your current term of office?
I am currently serving my second term (September 2013-September 2016). In addition to attending Board of Governors meetings four times per year and the CAP national meetings, I have been appointed to serve on several councils and board committees during my tenure. I have been fortunate to be exposed to many areas of the College through these councils and committees. I have served as Vice-Chair of the Council on Membership and Professional Development (CMPD) and participated in all of the Council meetings during the year I was on the Council. The CMPD is responsible for the membership activities, member benefits, and other activities such as practice management and the Peer-to-Peer program.

After the CMPD, I was appointed to the Council on Education (CoE) as Vice-Chair. During the year I was on the CoE, I learned the details of our learning program development and the work of the committees that reported to the Council. I contributed to the development of some of our education programs from the point of view of a pathologist in a community hospital practice.

I have served as Council on Accreditation Chair for the past two years, and have been engaged on the Laboratory Improvement Program (LIP) steering committee along with Dr. Bruce Williams (Chair of CSA) and senior CAP staff. We have been able to develop and present a sound LIP Strategy to the Board, and this was approved in March of 2014. Additional focus areas in the LIP Strategy will be developed later this year and presented to the Board for approval. As the Chair of the CoA, I also attend and participate in the Commission on Laboratory Accreditation (CLA) meetings and conference calls.

I have been a member of several other advisory groups in the College, including the Marketing and Sales Advisory Group, the Alliance Advisory Group, and the Continuing Medical Education Committee.

During the recent CAP Brand campaign, I was privileged to be a Brand Ambassador and provide information on the new Brand to our members.

The diverse areas of the College I have had the opportunity to participate in and contribute have provided me with a well-rounded experience in the College as a member leader. This experience will benefit me greatly during the rest of my tenure on the Board in my current position, or in the future position of Secretary-Treasurer should I be fortunate to be elected.

What major issues do you see facing the College during the next three years?
One of the biggest challenges the College faces in the near term is sustaining our growth and improving profitability in our laboratory improvement program (LIP), which consists of our PT Surveys, Accreditation, and other products. We need to be successful in meeting this challenge in order to provide the advocacy, education, and membership services we need and desire. However, it is not just enough to sustain growth and improve profitability; we need to use our financial and human resources efficiently and be fiscally vigilant and responsible.

The pressure by governmental and private payers will continue to challenge us and our practices, whether we are in private practice, academic, or industry environments. These challenges will come from Medicare and from other governmental payers such as Tricare and Medicaid, and from private payers. As these payers continue to look at test utilization for opportunities to decrease costs, the College will continue to be vigilant and supportive to help our members maintain their viability.

The genomic diagnostic arena will also impact us and will be integrated into the management of disease processes; in oncology, disease management, and disease prevention. The College is working to educate our members and provide them with a fundamental knowledge of genomics and next generation sequencing. While all pathologists will not need to be experts in these areas,

an understanding of the integration of genomic medicine will enable us to offer consultation and guidance to our professional colleagues with respect to test selection and utilization.

Advocacy efforts will continue to be focused on issues of reimbursement and regulatory changes that are occurring now and in the near term. The recent FDA draft on LDT Regulation will be closely monitored, and the CAP is engaged with the FDA and other stakeholders in this process. The impact on all of us, especially those in academic and industry environments, will likely be significant.

The Laboratory Improvement Program strategy will continue to focus on our PT products and accreditation processes. We will need to sustain our growth and market share in both proficiency testing and accreditation in an environment of competition from other organizations and the budgetary constraints that our clients are facing.

As Accountable Care Organizations continue to develop and expand, the CAP will face the challenge of providing us with the necessary tools and guidance to enable us to participate and engage in ACO's. In the recent past, this has been the responsibility of the Council on Government and Professional Affairs and will be shared in the near term by other areas in the College (Membership, Education).

Locally, our members in State Societies face unique challenges, such as the Beacon laboratory program in Florida. Our advocacy efforts for these societies will need to support our members and help them meet these challenges through legislation and lobbying. The importance of assisting the state societies cannot be understated in this rapidly changing healthcare environment.

If elected, what do you hope to accomplish?
As an officer of the CAP, I intend to help develop consensus among our member leadership in the utilization of our valuable financial, staff, and member resources. We cannot sustain our advocacy efforts and educational offerings without growing and sustaining our revenue stream and market share of our Laboratory Improvement Program. The budget planning carried out with the CAP staff leadership will be critical to our strategies and our ability to meet the many challenges that develop in the near and far term. Our members and their patients deserve our best efforts in this regard.

Whatever we accomplish we will do so together; with the help of our volunteer members who devote their time on our committees and councils, working with CAP staff to promote our vision and mission. We must engage our members appropriately, for the right reasons, and at the right time. The better we are at engaging our membership, the more likely success will follow. Our profession depends on all of us accomplishing these goals, and enable all of us, our patients, and our professional colleagues will reap the benefits of our accomplishments. We should strive to exceed and overachieve, and in doing so we will preserve our profession and our viability. As a practicing pathologist, I have professionally benefited from the CAP's advocacy efforts, educational offerings, and practice management tools; and I promise to continue my efforts on the Board on behalf of our membership, ensuring the College continues to offer us the best we deserve.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Secretary-Treasurer

George F. Kwass, MD, FCAP

Holy Family Hospital at Merrimack Valley
Haverhill, Massachusetts

Age: 82
Years in Practice: 52
Boards: AP
Education: Received MD, 1957, New York University of Medicine, New York, New York; Internship: Boston City Hospital, Boston, Massachusetts; Residency: Massachusetts General Hospital, Boston, Massachusetts; Traineeship in Steroid Biochemistry: Worcester Foundation for Experimental Biology, Shrewsbury, Massachusetts

Employment Status: Full Time
Practice Type: Hospital/Community Based Laboratory
Practice Size: 1-5

CAP Experience:

2009-present	Governor
2013-present	Member, Executive Committee
2009-present	Member, Finance Committee
2010-present	Member, Audit Committee
2011-present	Member, Compensation Committee
2012-present	Member, Investment Committee
2009-2013	Member, Strategy Management Committee
2013-present	Chair, Council on Government and Professional Affairs
2011-2013	Vice Chair, Council on Government and Professional Affairs
1989-1994 & 2006-2011	Member, Council on Government and Professional Affairs
2013-present	Member, CAP Political Action Committee (PathPAC)
2013-present	Member, Policy Roundtable Committee
1989-1993 & 2006-2009	Chair, Economic Affairs Committee
1983-2009	Member, Economic Affairs Committee

Experience in Other Organizations:

- Board of Directors, Holy Family Hospital
- Founding Member, AMA RBRVS Update Committee (RUC)
- Chair, Research Subcommittee, AMA RUC—instrumental in development of RUC procedures, methodologies, and policies.
- Past President, Massachusetts Society of Pathologists

- Chair, Legislative Committee, Massachusetts Medical Society
- Chair, Judicial Committee, Massachusetts Medical Society

Why do you want to be a governor or officer of the College?
We each bring our own vision of the CAP's purpose to the table, and attempt to influence its behavior in the service of that vision. I see the College as the enabler of professional self-fulfillment of its members. I am agnostic as to where any member derives that satisfaction, be it in competence, mastery, socio-economic comfort, lifestyle, authority, intellectual satisfaction, or, as with each of us, some unique blend of all. The Board needs leaders and participants with a balanced view of member interests in order to fulfill its responsibilities to those who elect it. By virtue of temperament, experience, and outlook, I believe I bring an appropriate perspective to the Board.

I have served the College continuously since 1983, primarily in multiple advocacy roles, until my election to the Board in 2009. At that time, I added committee responsibilities in finance, investment, compensation, and audit to my portfolio. In those positions, I acquired significant insights into the multifaceted and intricate operations of the organization in carrying out its noble mission. As Secretary-Treasurer, I would be enabled to use this knowledge earlier in the budgeting process to help ensure an appropriate distribution of resources to meet the CAP's goals as articulated in its mission statement, in the OPEN cascade, and by the Board through its various actions. The Secretary position also carries with it the responsibility for maintenance and updating of policies. I bring extensive experience in that space from outside activities in policy development, articulation, and implementation from executive roles in my hospital and its network, the Massachusetts Medical Society where I served, inter alia, as chair of the Judicial Committee, and in my role as a founding member of the AMA RUC and first chair of its research subcommittee, developing its first set of policies and procedures and maintaining and modifying them subsequently.

In addition to what abilities and knowledge I bring to the Board, I also enjoy participation in the decision-making process of the organization, the discussion and debate over strategy, policy, priorities, and the detail of tactic and implementation. To perform any job well requires job satisfaction, which depends both on contributing and being contributed to.

How do you assess your contribution to the CAP Board of Governors during your current term of office?
With all due modesty, I believe I have contributed significantly to Board deliberations, particularly in the realms of advocacy, member interests, finance, and budget. I have diligently attended the regular Board meetings and the Board committee meetings, as well as the relevant Council and committee meetings in both my chair and vice chair roles. As a tireless advocate for member and organizational interests, I have challenged vigorously some of the common dogmas and have attempted to influence decisions to protect our interests as practitioners of pathology, and to maintain an appropriate financial focus for the CAP business endeavors. I bring to the Board one of the broader perspectives based on my many years as a general pathologist, laboratory

director, and department chair in small group practice, abetted by significant additional experience in organized medicine and pathology, as well as medical staff governance and hospital administration. This experiential array enables me to articulate a vision of the future for pathology and its continuing role in the house of medicine. I see us adding incrementally new technologies, enhancing our roles as diagnosticians by combining the anatomic and clinical laboratory components of our knowledge base.

Experience has taught me the importance of team play; once Board decisions are made I promote them enthusiastically, whether or not I was in agreement initially. This is not to imply a lockstep approach to decision making. We are a cadre of highly trained, intellectually gifted professionals where disagreement and differences of perspective are not only to be accepted, but also cherished. Rigidity should not foreclose discussion, but from the organizational perspective, decisions must be supported or chaos results.

I also bring a diligence to my Board activities. I read all agenda material and other informational documents sent to me, prepare for any presentations I make, read and comment when necessary on policies submitted for evaluation, renewal, or elimination, and generally try to be prepared on the issues. This is an approach to responsibilities critical to success as an officer, where leadership is an expectation.

What major issues do you see facing the College during the next three years?
I would divide this question into two parts: issues facing the CAP as an enterprise, and issues facing the profession of pathology and its practitioners. As to the first, the business enterprise of the College is challenged by lower priced proficiency testing (PT) products in the commodity sector of the marketplace. PT sales is the financial engine that drives the majority of revenue, and its preservation is critical to the ability of the organization to carry out its many other functions, particularly member advocacy and education. The market in which our customers operate is under significant financial pressure from both governmental and private payers. Price sensitivity is a constant threat to our high quality but expensive product line. Increasing costs of the goods we must buy and ship are an additional problem, potentially affecting our margins. Our to-date successful foray into the international space has presented many challenges, particularly with respect to delivering viable product to our customers where climatological and importation issues plague us. Our accreditation program is challenged by the JCAHO, but we have been successful to date in increasing the numbers of laboratories accredited. Constant monitoring of the marketplace and adoption of strategies to maintain our premier position are critical to our continued success.

On the member side of the equation, we are all familiar with the challenges we face. Payment policies and amounts are under scrutiny in the public and private sectors. Our services on both the professional and technical sides are under constant review for utility and cost. Local coverage determination methodology has been expanded in an attempt by government payers to limit our professional judgments and activities. The FDA is attempting to regulate laboratory-developed tests in a manner inconsistent with continued innovation and development. CMS has hired Rand and Urban Institute to review relative values across all of medicine, particularly with respect to

equity and the accuracy of the time estimates underlying those values. The current employment outlook for pathologists is somewhat less than robust, and this could decline even further should payment amounts be reduced, resulting in the currently employed increasing productivity. The “value-based” component of our reimbursement will continue to increase, emphasizing an outcome oriented perspective difficult for diagnostic physicians to meet. The perceptions and realities surrounding these issues have resulted in fewer qualified candidates applying for and filling residency positions.

If elected, what do you hope to accomplish?
I plan to continue the finance committee processes of completing the budget within the prior fiscal year, and of establishing a 10-year budget projection maintaining the Board-established floor to the reserve funds. Additional retrospective analyses, comparing actual performance to prior projections and business plans created at project launches, would assist the Board in assessing the credibility of such projections in the future. Total budgetary transparency is necessary for the Board to have confidence in its decision-making process, and for the membership to have confidence in the integrity of the Board. Although a formal annual report to the membership may not be necessary, a report highlighting the IRS Form 990 filings would help to alleviate some of the suspicion and distrust of College management harbored by a segment of our Fellows. In my role as chair of the finance committee, I would institute a mid-year review of current progress against metrics and of anticipated activities for the next year with fiscal notes attached.. This would enable the finance committee to be more involved in the priority setting and honing of the budget, so that timely recommendations to the Board can be made regarding strategic direction.

As to the Secretary role, I would undertake a phased review of all CAP policies to be certain that they are current, appropriate to present circumstances, and are not contradictory. The significant changes we have undertaken in branding, marketing, laboratory improvement, education, and advocacy now require such comprehensive review.

Finally, as an officer and thought leader of the Board, I would endeavor to maintain a role as a questioner of decisions that appear to be made based on dogma and tradition or that serve narrow interests, asking for "zero-based" reflection on significant strategic initiatives. I would also continue to advocate for the consideration of broadly defined member interests as the fundamental underpinning of College activities.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Secretary-Treasurer

Gail H. Vance, MD, FCAP

Indiana University School of Medicine
Indianapolis, Indiana

Age: 64
Years in Practice: 23
Boards: CP, Pediatrics, Clinical Genetics, and Clinical Cytogenetics
Education: Received MD, 1980, College of Human Medicine, Michigan State University, East Lansing, Michigan; Internship: William Beaumont Hospital, Royal Oak, Michigan; Residency: University of Minnesota, Minneapolis, Minnesota; Fellowship: Indiana University School of Medicine, Indianapolis, Indiana

Employment Status: Full Time
Practice Type: Academic
Practice Size: 1-5

CAP Experience:

2005-2012	Governor
2010-2012	Liaison, CAP Foundation Board of Directors
2011-2012	Member, Executive Committee
2011-2012	Chair, Council on Education
2012-2014	Advisor, Council on Education
2010	Member, Learning Strategy Advisory Group
2014-present & 2008-2011	Member, Personalized Health Care Committee
2014	Chair, CAP Nominating Committee
2012-2013	Member, CAP Nominating Committee
2012-2013	Member, Policy Roundtable Committee
2009-2013	Member, Transformation Program Office Steering Committee (TPOSC)
2011-2013	Member, TPOSC Module IV: Emerging Technology
2007-2010	Member, Ad Hoc Committee on Laboratory Quality and Improvements for the 21st Century (LQI-21)
2009-present	Chair, LQI-21 Laboratory Developed Tests Working Group
2008-2009	Member, Ad Hoc Committee for Center Plan Development
2005-2007	Member, Council on Accreditation
2006-2007	Member, Checklists Committee
2005-2006	Member, Finance Committee
2005-2009	Member, Council on Scientific Affairs (CSA)

2008	Co-Chair, Heterogeneity and HER2 Testing Working Group
2005	Chair, CSA Molecular Pathology and Genomics Cluster
2003-2005	Member, Molecular Oncology Committee
2002-2005	Chair, CAP/ACMG Cytogenetics Resource Committee
1998-2001	Member, CAP/ACMG Cytogenetics Resource Committee

Experience in Other Organizations:
I am currently president and have been a founding member of Indiana University (IU) Genetic Services LLC, Incorporated, and have served in every officer position, leading the group to financial strength and sustainability. I was tapped by the President of IU to sit on an expert panel to determine the future of the IU Graduate School.

Further, I have been selected to be a member of several groups working to establish guidelines for our profession:

- CAP/ASCO Expert Panels (2006-2007 and 2012-2013) for establishing professional guidelines for performance and interpretation of HER2 diagnostic testing in breast cancer
- HHS Secretary's Advisory Committee on Genetics, Health and Society, “Oversight of Genetic Testing” 2007-2008
- Clinical Laboratory Improvement Advisory Committee (CLIAC); U.S. Dept of Health and Human Services 2010-2013
- CLIAC Working Group on Molecular Genetic Testing, sponsored by the Centers for Disease Control, 2008
- American Society of Human Genetics (ASHG) Nominating Committee 2003
- ASHG Meeting Abstract Review and Cytogenetic Session Co-Chair
- ASCO Breast Cancer Consensus Panel 2014
- ASCO University Cancer Genetic Program 2014
- Committee to Assess Clinical Utility of NGS, Green Park Collaborative.
- AMP Finance committee

Why do you want to be a governor or officer of the College?
CAP is a profound and respected professional organization. Its success lies in its history, credibility, and continued focus on high quality and excellent healthcare. Its "wealth" is the membership, who volunteer hours upon hours of their expertise, and are joined by a dedicated staff who willingly assist and actualize the members’ collective work. As Secretary-Treasurer, I will contribute to CAP’s continued success, and ensure that CAP policies and finances support the College's mission and both sustain and advance our members and the specialty of pathology now and into the future.

What is the strongest contribution you could make to the CAP Board of Governors if you are elected?

- Practicing pathologist and clinician
- Strong management and interpersonal skills

- Broad and detailed knowledge of College operations
- Skilled negotiator who seeks collaborative outcomes
- High sense of ethics
- Deep commitment to patient care

What major issues do you see facing the College during the next three years?
The healthcare environment remains volatile. The political atmosphere is charged with a very deep partisan divide within Congress and between Congress and the White House. Pathology and pathologists must navigate increased regulatory reforms potentially increasing costs of diagnostic testing, all the while encountering decreased reimbursement for services. We must skillfully steer through these rough seas by mitigating cuts in new payment models; continuing to seek payment for new services, such as genomics, informatics, and in vivo microscopy; while advancing the quality and safety of diagnostic testing. We must also continue to be vocal advocates of our role in healthcare and demonstrate our value at all levels of government, to patients, and other medical specialties. It is also critical to support, improve, and expand our revenue-generating services in the increasingly competitive laboratory improvement environment.

If elected, what do you hope to accomplish?
I would continue to advocate for dialogue including a dialogue with our members, listening to their concerns and keeping them informed. We must continue to engage in conversations with the regulatory agencies and legislators, with sister pathology groups, and other professional organizations such as ASCO. We must continue to work collaboratively on issues with these groups when our initiatives align. CAP has the reputation and infrastructure to lead and support novel regulatory standards for clinical diagnostics and we should seriously consider adopting a major role in regulatory reform.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Governor

Edward P. Fody, MD, MS, FCAP

Western Michigan Pathology Associates, PLLC
Holland, Michigan

Age: 67
Years in Practice: 35
Boards: AP/CP
Education: Received MD, 1975, Vanderbilt University, Nashville, Tennessee; Residency: Vanderbilt University; Fellowship: University of Texas, Houston, Texas; Received MS (Chemistry), 1971, University of Wisconsin, Madison, Wisconsin

Employment Status: Semi Retired
Practice Type: Hospital/Community Based Laboratory
Practice Size: 1-5

CAP Experience:

2015-present	Advisor, New in Practice Committee
2011-present	Advisor, Member Engagement Committee
2011-2013	Member, Case for Change Initiative Project Team (Module I: Supply and Demand)
2010-2011	Member, CAP Foundation Futurescape Planning Committee
2006-2007	Vice Chair, Member Benefits Committee
2008-2010	Advisor, Member Benefits Committee
2004-2005	Member, Member Development Committee
2003-2004	Chair, Insurance Committee
2000-2002	Member, Insurance Committee
1992-1995	Chair, Conjoint Committee on Pathology Enhancement
1985-1993	Member, Publications Committee
1980-1984	Chair, Patient Preparation and Specimen Handling Committee

Experience in Other Organizations:

- President, Michigan Society of Pathologists
- Former President, Ottawa County (MI) Medical Society
- President, Cincinnati Society of Pathologists
- Member, Board of Governors, Ohio Society of Pathologists
- Co-authored over 25 publications
- Co-editor, best selling clinical chemistry textbook "Clinical Chemistry: Principles, procedures, Correlations" (currently in 7th edition)
- Authored many other textbook chapters

Why do you want to be a governor or officer of the College?
I have been a Fellow of the CAP since 1980, and I've always been extremely active in this organization. I have enjoyed the time I've spent on developing new products (such as *CAP Today*) and working with our members to enhance our services (insurance, LAP program) and in working and counseling younger members.

There is no other organization like the CAP, and I would like to help our members by giving back what I've learned in 35 years of private practice.

What is the strongest contribution you could make to the CAP Board of Governors if you are elected?
Putting members first

What major issues do you see facing the College during the next three years?

- Legislative issues, both at the state and federal levels: The CAP needs to be the members' voice in Washington and state capitals.
- Technology issues: Molecular pathology, imaging, and new instrumentation such as rapid sequencing all present marvelous opportunities for pathologists. We need to assist our members in making them work for their practices.
- Information issues: We must help pathologists to ensure that they remain in charge of pathology and laboratory information.
- Workforce issues: We are facing a relative shortage of pathologists in the next decade. We need to help our members to retain control of emerging technologies and to practice more efficiently.

If elected, what do you hope to accomplish?
If I am fortunate enough to be elected, I will do everything I can to make the CAP work for its members and to put members first.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Governor

Gerald R. Hanson, MD, PhD, FCAP

Memorial Health Services
Huntington Beach, California

Age: 66
Years in Practice: >30
Boards: AP, Hematopathology
Education: Received MD, 1973, University of California Irvine, Irvine, California; Internship: Orange County Medical Center, Orange, California; Residency: University of California Irvine Affiliated Hospitals, Orange and Long Beach, California; Fellowship: Long Beach Memorial Medical Center, Long Beach, California

Employment Status: Retired
Practice Type: Hospital/Community Based Laboratory

CAP Experience:

2014-present	Governor
2014-present & 2003-2005	Member, Council on Government and Professional Affairs
2014-present	Member, Council on Membership and Professional Development
2015-present	Liaison, CAP Foundation Board of Directors
2011-2014	Member, ACO Steering Committee and Advisory Network
2012-2013	Member, Technology Assessment Committee
2010-2012	Member, Case for Change Initiative Project Team
2008-2014	Member, Economic Affairs Committee (EAC)
2012-2013	Chair, Regulatory Compliance Subcommittee of EAC
2010-2011	Chair, Professional Affairs Committee
2006-2009	Member, Professional Affairs Committee
2007	Member, CAP Nominating Committee
2003-2005	Vice Chair, Practice Management Committee

Experience in Other Organizations:
California Society of Pathologists: Board Member for over 20 years, served as Treasurer, Vice President and President. I initiated the expansion of practice management with a new membership category. I also served as the representative to the Medicare CAC (1996-2015), as a member of the Reimbursement Committee (1988-1992), and chair of the Practice Management & Compensation Committee (1992-2004).

American Pathology Foundation: Board member for 12 years, Treasurer and Executive Committee (2006-2008), task force for strategic planning and selection of new management company

Church Council: Treasurer

Boards of two physician organizations (PPO, IPA): Extensive experience for over ten years with contracting, payment issues, and capitation risk management

Why do you want to be a governor or officer of the College?
I had the good fortune to be mentored and introduced to the activities and importance of state and national professional societies shortly after I entered practice. In California, the 1980s and1990s were a time of monumental change and economic threats, manifested by heavy penetration of advanced managed care models including full capitation, risk bearing intermediary physician organizations, pay for performance models and restructuring of physician groups and delivery systems. This necessitated adaptation to alternative payment models, honing of practice management skills, and strong state pathology society advocacy. This has proved to be a fertile training ground for me personally. For more than a decade, I have expanded my healthcare policy, advocacy, and practice management interests by serving on several councils and committees of the CAP in the advocacy and practice management arenas. Last year I was appointed by the Board of Governors to fill an unexpected vacancy.

Today's environment is unprecedented in the magnitude and rate of changes that are dramatically altering the healthcare landscape. My experience, technical and leadership skills, and strong interests in areas that are important in meeting the challenges we face prompt me to desire to continue the privilege of serving CAP and its members as a Governor.

How do you assess your contribution to the CAP Board of Governors during your current term of office?
As a Governor (since April 2014) I have served on the following Councils and committees:

- Board of Governors: Regularly attend meetings; ambassador for the Branding Initiative; support expanded business discipline capacity and cross council initiatives.
- Council on Government and Professional Affairs (CGPA) and CGPA Executive Committee: Regularly attend meetings and contribute to policy development.
- Council on Membership and Professional Development (CMPD): Regularly attend meetings and appointed to the new State Pathology Society Advisory Group.
- Liaison to the CAP Foundation Board of Directors: Support See Test and Treat banner program.
- Economic Affairs Committee (EAC) and EAC Executive Committee: Participate regularly in face-to-face meetings and the weekly Chair's call reviewing subcommittee reports on issues and preparation for RUC/PEAC meetings, comment letters and testimony at hearings and discussion of issues position development, strategy, and tactics.

What major issues do you see facing the College during the next three years?
The transition from a primarily fee-for-service (FFS) volume driven to a "value based" system continues and the pace and impact appears to be accelerating. The focus on cost and quality brings huge challenges. Physician payment reform is lowering FFS payments. Greater numbers of pathologists are faced with alternative payment models, some for the first time, and there are new payment models emerging. Healthcare delivery reform is resulting in a resurgence of mergers, acquisitions and integration efforts that may require pathology groups to respond to fit into or provide an opportunity. In addition, the administrative burden and cost of evolving quality programs (meaningful use, PQRS, and VBM) is large and pathologists face additional revenue losses as the programs shift to the expanding penalty phase. The CAP must be vigilant in its advocacy efforts as the primary advocacy organization for pathologists and laboratory medicine and expand activities at the federal and state level. Increasing private sector coverage determinations and emerging laboratory benefit programs will require increased CAP advocacy resources. CAP provides education and practice management tools to assist pathologists to cope with these challenges.

Financial pressures on customers of laboratory improvement services (accreditation, PT) require increased competitiveness, efficiency, and marketing business discipline. Technological advances in genomics, nanotechnology and bioengineering, etc, impact virtually all areas of CAP (scientific, advocacy, education, and lab accreditation).

Societal changes and expectations for increased transparency, access, and accountability for quality and cost are changing the healthcare and regulatory landscape.

If elected, what do you hope to accomplish?
1. Promote involvement in advocacy efforts including expanded activity at the state level and private sector. Increase grassroots member engagement to help achieve.
2. Promote/expand intersociety collaborative programs to improve advocacy outcomes and unify the voice of pathology to gain full recognition of the value of pathologists and their important role in healthcare delivery
3. Educate and assist pathologists with new technology to improve patient care within the context of the healthcare paradigm.
4. Increase education and resources in practice management for pathologists.
5. Focus efforts on building membership of both CAP and state societies by adding value for mutual benefit.
6. Promote cross council collaboration to accelerate decision making and be more nimble and responsive.
7. Continue progress on improving CAP business discipline and efficiency to improve competitiveness in the laboratory improvement program.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Governor

Richard H. Knierim, MD, FCAP

Swedish Medical Center
Seattle and Bellevue, Washington

Age: 69
Years in Practice: 39
Boards: AP/CP
Education: Received MD, 1970, Loma Linda University, Loma Linda, California; Rotating Internship and Pathology Residency: University of Washington, Seattle, Washington

Employment Status: Semi Retired
Practice Type: Hospital/Community Based Laboratory
Practice Size: 1-5

CAP Experience:

2008-present	Delegation Chair, House of Delegates (Washington State Delegation)
1983-1991 & 1995-present	Delegate, CAP House of Delegates
2011	Member, CAP Nominating Committee

I worked closely with CAP advocacy staff on passing legislation in State of Washington about direct billing and electronic health record "donations" by laboratories to private physician practices. These legislative actions were successful, in spite of opposition by other specialty groups (dermatology, urology, gastroenterology).

Experience in Other Organizations:

- Pathology representative to Washington State Medical Association Advocacy Council (2002-present)
- Washington State Society of Pathologists (WSSP): President (2002-2004); Executive Committee member (2000-2012); very involved in educational and political activities of the state pathology society
- Laboratory of Pathology of Washington, Seattle, WA: general pathologist, dermatopathologist, and board member (1990-1995)
- Washington Pathology Consultants, Seattle, WA: board member, general pathologist and dermatopathologist (1995-2005)
- CellNetix Pathology and Laboratories, Seattle, Everett and Olympia, WA: founding pathologist, general pathologist, dermatopathologist (2005-2013); Co-director, Ophthalmic Pathology Service (2006-2013)

- Fred Hutchinson Cancer Research Center, Seattle, WA: Consultant, Cancer Surveillance System (1993-2005)
- Deaconess Medical Center, Spokane, WA: Pathology Services, PS, general pathologist (1982-1990); Laboratory Director (1984-1985)
- Sacred Heart Medical Center, Spokane, WA: general pathologist, special interest in hematopathology (1978-1982)
- Spokane Medical Library: Board Member and President (1980s)
- Madigan Army Medical Center, Ft. Lewis, WA: general pathologist (1976-1977); active in hematopathology service, chief of anatomic pathology during part of 1977
- US Army Hospital, Okinawa, Japan (1975-1976): chief of pathology during part of 1976.
- Knierim Pathology, PLLC, Bellevue, WA (2015): general pathologist, dermatopathologist, second opinions. pathologistsoncall.com

Why do you want to be a governor or officer of the College?
I have worked at small, medium-sized, and large hospitals, in laboratories with abundant inpatient and outpatient work. I am at the stage of my career which allows focus on evolving projects and future needs of the College.

I believe that I have experience, insight, and abilities to help the College with many important projects and issues.

What is the strongest contribution you could make to the CAP Board of Governors if you are elected?

- Help other members of the Board of Governors identify and implement projects which will allow pathologists be more productive
- Keep a patient focus in all projects
- Communicate activities and goals of the College to residents and state pathology societies (similar to activities of Paul Valenstein)
- Encourage interaction with other specialty societies.
- Work on major issues facing the college (see below).

Helpful sounding boards: many pathologists in the state of Washington and elsewhere. One good friend is a professor at University of Washington with PhD in economics from UC Berkeley and law degree from Stanford. Another friend is former Vice Provost for Research and former Chair of Chemistry at University of Washington, with degrees from Harvard & Caltech. Other good friends are clinicians in OB/GYN and urology.

What major issues do you see facing the College during the next three years?

- Increased use of molecular pathology/genome science data for lesion diagnosis and patient treatment
- ICD 10 implementation
- Accountable Care Organization relationships with pathologists

- Revised ethics guidelines for American Medical Association
- Food & Drug Administration (FDA) regulations about laboratory-developed tests (LDTs)
- Affordable Care Act (ACA) implementation—uncharted territory may have too few practitioners to meet needs of insured
- Laboratory benefit management services such as United Healthcare's lab program, accessed through Beacon Laboratory Benefit Solutions (described by clinicians as "onerous, burdensome, and disruptive to workflow")
- Shared decision making in patient care
- Difficulty in communication between electronic health record systems; prior authorization and network access
- Insurance authorization for clinically needed tests such as comparative genomic hybridization (CGH); work by CAP advocacy to preserve fair payment
- Improved information technology for organizing and processing data
- Increase general knowledge of pathologists' activities in health care system ("brainiac" designation on crime dramas may help; public relations effort important)

If elected, what do you hope to accomplish?
This question brings to mind attributes of CAP leaders well described by Gene Herbek in December 2014 *CAP Today*. I hope to smooth the path for other pathologists and mentor those who follow.

Loyd R. Wagner, with a warm handshake, welcomed me into the House of Delegates in the early 1980s. He commented that I was one of the youngest at that meeting. I was not surprised to learn that he urged that residents be appointed to councils and committees.

William B. Hamlin was a “boisterous, forthright and fearless” individual who worked many hours to advance issues and projects important to the College. I am proud to say that Bill Hamlin was my mentor, and strongly supported my move from Spokane, WA into his group in Seattle near the end of his time as Laboratory Director at Laboratory of Pathology of Washington.

Jerald R. Schenken taught that “there is no such thing as a permanent adversary and that we owe it to one another to deal with political issues that affect our practices.”

I hope to use political skills learned while working with Barry Ziman, his associates, members of the State of Washington Senate and House of Representatives and lobbyists to advance issues of importance to patients and pathologists.

An area of interest: resolution for CAP to take leadership role in defining functionally important disorders of the placenta, adopted by CAP House of Delegates, 1989. (Refer to Arch Pathol Lab Med 115 : 647-731, 1991 and Arch Pathol Lab Med 121:449-476, 1997). There was discussion at the California Society of Pathologists in December 2014 about clinical reasons to revise indications for microscopic examination of placentas.

I will bring to the Board of Governors much that I have learned during more than a decade as pathologist representative to Washington State Medical Association Advocacy Council. [The February 2015 meeting had a legislative update by WSMA attorney/lobbyist, a talk about prior authorization and network access rule making by a special assistant to the State of Washington Insurance Commissioner, an update on activities of the Washington State Urology Society by a past president of the American Association of Clinical Urologists (including reference to Physician Led Team Based Care - example: in-office ancillary exception to Stark Law; problems with current recommendations about prostate cancer screening), and development of a core performance measure set for the State of Washington ($65 million federal grant)].

As a dermatopathologist, I am acutely aware of debates about ethical issues between dermatologists, dermatopathologists, and pathologists.

Among publications read regularly: CAP Today, Archives of Pathology, CAP StatLine, New York Times, Wall Street Journal, Steve Sjuggerud's True Wealth & DailyWealth Premium, The Growth Stock Wire / Stansberry Resource Report, Nathan Slaughter's High-Yield Investing, Porter Stansberry's Digest & Venture & Short Report & TrueWealth Systems, newsletters from Mauldin Economics, and David Eifrig's Retirement Trader.

Other activities will include:

- Help other members of Board of Governors and CAP officers identify and implement projects which will allow pathologists be successful in a variety of practice settings.
- Assure continued financial success of the College.
- Encourage patient focused emphasis on all projects.
- Work for interaction with other specialty societies.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Governor

Raouf E. Nakhleh, MD, FCAP

Mayo Clinic Florida
Jacksonville, Florida

Age: 54
Years in Practice: 26
Boards: AP
Education: Received MD, 1985, Wayne State University, Detroit, Michigan; Residency and Fellowship: University of Minnesota, Minneapolis, Minnesota

Employment Status: Full Time
Practice Type: Hospital/Community Based Laboratory
Practice Size: 11-15

CAP Experience:

2013-present	Member, Council on Scientific Affairs (CSA)
2010-present	Chair, Center Guideline Projects • Center CAP/ADASP Effective Communication of Urgent Diagnoses and Significant Unexpected Diagnoses in Surgical Pathology and Cytopathology Work Group • Center CAP/ADASP Interpretive Diagnostic Error Reduction in Surgical Pathology and Cytopathology Panel • Center CDC Guideline Metrics Expert Panel Project Team
2010-present	Member, Center Committee
2006-present	Member, Gastrointestinal Cancer Protocols Panel
2013	Chair, CSA Laboratory General Cluster
2012-2013	Member, CAP Nominating Committee
2011-2012	Member, Standards Committee
2010-2013	Chair, Quality Practices Committee
1994-2001 & 2006	Member, Quality Practices Committee
2008-2009	Member, Ad Hoc Committee for Center Plan Development
2007-2009	Vice Chair, Quality Practices Committee
2006-2009	Member, Archives Editorial Committee
2006-2008	Member, AMA Physician Consortium for Performance Improvement, Pathology Performance Measures Development Working Group
2000-2005	Member, Surgical Pathology Committee

Why do you want to be a governor or officer of the College?

1. First and foremost, I want to be a Board member to make sure that the priorities of the College of American Pathologists remain focused on patient care.
2. Second, I want to make sure that pathologists are recognized, appreciated and compensated for our work.
3. I care deeply about the College of American Pathologists, I want to see the College of American Pathologists maintain and expand its leading role as the principle organization in pathology. In my work on various committees and councils, I have found tremendous satisfaction in being able to participate in the shaping of our profession. I feel vibrant and relevant in the work I do for CAP. I want to be a Board member because I want to make sure that opportunities given to me are going to be there for future pathologists. The improvements that we hope to make and the solutions we seek will come from future pathologists who feel they have a home at CAP.

What is the strongest contribution you could make to the CAP Board of Governors if you are elected?

I believe I now have the experience and expertise to be a very effective board member. I have a strong record of accomplishment within the CAP. I have led and completed numerous projects within the CAP and fully understand the inner workings of the College. This gives me a tremendous advantage in tackling problems and getting things done as a Governor.

I have a strong background in Quality Assurance. I believe that knowledge and experience brings a very disciplined approach to solving problems. It is an approach that views problems and situations as they really are without influence by hype and emotion. I have great experience in understanding and analyzing problems that is grounded in evidence. I prefer to deal with and address a problem by fully evaluating available data and knowledge of the situation. Those skills coupled with fundamental principle of advancing patient care usually leads to resolution of problems.

What major issues do you see facing the College during the next three years?

There are at least 3 major issues that have to be addressed on an ongoing basis for the foreseeable future:

1. Ongoing challenges to payment for pathology services. In the past few years we have seen a seeming non-ending procession of efforts at limiting or reducing payment for pathology services, including the reduction of CPT code valuations, changes in CPT codes, and changes in local coverage determinations such as Palmetto's and United/Beacon's proposed imposition of new rules to limit testing.

   The CAP has continued to work with state pathology societies as well as others to mitigate these activities with variable success. I believe that in the current climate, the strongest case we can make to protect payments for pathology services is to demonstrate the relevance of those services to patient care.

2. The CAP has to maintain and grow its current businesses. CAP businesses – laboratory accreditation and proficiency testing – by themselves promote high quality laboratory practices. However, they also generate capital that enables the CAP to improve the practice of pathology such as cancer protocols and the development of practice guideline. This capital is also used for ongoing lobbying efforts to protect and promote the specialty.

3. CAP must keep its focus on patient care, and do everything in its power to promote good practices that enhance patient care.

If elected, what do you hope to accomplish?

1. I would like to continue working on the Center Committee in the area of guideline development. I think this is important in two ways. First, guidelines help establish and set the standard of practice. Second, I believe there will be an increasing connection with regulators and others to tie payment with meeting standards of care.

2. I would like to be a leader of the Council on Scientific Affairs. In that role, I would like to see mechanisms established that promote cross-committee and cross-council collaboration.

3. I would like to develop mechanisms to collect data on certain practices when a particular problem arises. For example, as the FDA is proposing oversight of laboratory developed tests (LDT's), I feel that an organization such as the CAP should have real data that demonstrates the extent and variety of LDT's that are used. I believe that an argument for or against a practice is always enhanced with the inclusion of real data.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Governor

Michael B. Prystowsky, MD, PhD, FCAP

Albert Einstein College of Medicine/Montefiore Medical Center
Bronx, New York

Age: 62
Years in Practice: 30
Boards: CP
Education: Received MD, 1981, University of Chicago, Chicago, Illinois; Residency: University of Chicago, Chicago, Illinois; Received PhD in Biomedical Sciences, 1978, City University of New York at Mount Sinai, New York; Fellowship in Protein Chemistry/Immunology: Rockefeller University, New York

Employment Status: Full Time
Practice Type: Academic
Practice Size: 31 or more

CAP Experience:

2012-present	Governor
2014-present	Chair, Council on Education
2014-present	Member, Executive Committee
2014-present	Member, Council on Accreditation
2014-present	Member, Risk Management Committee
2014-present	Liaison, Association of Pathology Chairs Roundtable
2012-2013	Member, Transformation Program Office Steering Committee
2013 & 2015	Host, See Test and Treat

Experience in Other Organizations:
For the past two years as chair of the undergraduate medical education committee, we have been working closely with more than 60 pathologists nationally to develop learning objectives for teaching pathology to medical students (*Archives of Pathology*, March 2014). The "learning competencies" is a living document that is being used nationally at LCME accredited medical schools to guide pathology teaching (www.apcprods.org/UME/Competencies). We are continuing to improve this national resource by developing cases to complement the learning objectives.

For the American Cancer Society beginning in the 1980s, I served on several peer review groups, chaired peer review groups and chaired the Council on Extramural Support. I currently chair a committee that reviews new appointees to the peer review groups.

I serve or have served on several committees at Einstein and Montefiore including the following:

- Chair, Tenure Review Committee
- Director of Shared Resources for the Cancer Center
- Executive Committee of the Cancer Center
- Executive Advisory Committee of the Medical Scientist Training Program
- Chair of Board, Federated Practice Plan

Why do you want to be a governor or officer of the College?
Before becoming a governor I observed the challenges we faced to bring different elements of the pathology community together (research and clinical, academic and community practice, etc). With the ever-changing healthcare delivery and payment models, it is imperative that pathologists band together and speak with a strong voice for our profession. While working on the transformation program at the CAP, it was clear that pathologists from diverse backgrounds have much in common. I will use my multifaceted experience as an educator of future pathologists, a manager of a large clinical operation, chair of a pathology service of the best performing pioneer ACO in the US and a translational researcher to develop and advance programs to support CAP members. The future of our discipline relies on a strong bond between all pathology phenotypes to secure our future.

I have had a unique opportunity during the past two years to connect pathologists from all practice environments through educational efforts. This is possible because I chair both the Undergraduate Medical Education Committee of APC and the Council on Education (COE) for CAP. For undergraduate medical education, pathologists from many practice settings have contributed to developing national standards for teaching pathology to all medical students (www.apcprods.org/UME/Competencies); there are three competencies including Disease Mechanisms, Organ System Pathology and Diagnostic Medicine. Pathologists teaching diagnostic medicine to all medical students will solidify our role as experts in this area for all practice settings – this long-term educational approach fits well with the CAP goal to "Make Pathologists Known." Another education effort bridges the Graduate Medical Education (GME) Committee of APC with the COE and Council on Scientific Affairs (CSA); we have developed a test utilization course for residents that teaches both common problems in test selection and how to interact with ordering physicians. Over one third of our members are required to participate in maintenance of certification (MOC). A third major effort of the COE is to develop programs and processes that will facilitate learning opportunities and record keeping for our members to comply with MOC. Finally the COE and CSA are working together to evaluate course offerings and needs for more experienced pathologists.

My goal for the next three years is to continue these efforts to enhance the competency and visibility of all members. It will be a privilege to continue to serve.

How do you assess your contribution to the CAP Board of Governors during your current term of office?

My major contribution has been through education by engaging pathologists nationally, developing collaborative projects between APC and CAP and facilitating interaction between CSA and COE to accomplish the following:

1. Improve the competency of pathologists as experts in diagnostic medicine;
2. Improve the visibility of pathologists as experts in diagnostic medicine to medical students and to clinician colleagues as integral physician members of healthcare teams; and
3. Improve the ability of new in practice pathologists to maintain certification by developing programs and processes required for compliance.

As a governor, it is important for me to understand the core business of the College. I serve on the Council on Accreditation (COA) and have participated in nine inspections during the past year (one domestic, two Department of Defense in Japan, and five international in India). I have learned through meetings and council conference calls our strategic plans to improve our services; I have seen firsthand how our customers view of our programs and how much they value being CAP accredited.

I have made, and plan to continue to make, a significant commitment to carrying out my responsibilities to CAP. My attendance at meetings (Board, Executive Committee, COE, COA, Risk Management) and participation in conference calls has been nearly 100% for the past two years. The diversity of pathologists (practice settings, age, specialties etc.) that contribute to the discussions in the various committees, councils and board is amazing. This vibrant dialogue ensures that all voices are heard. As a governor, I view my responsibility to listen to all perspectives, give thoughtful consideration to all points of view, and work for the benefit of members.

What major issues do you see facing the College during the next three years?

All practicing pathologists are faced with challenges to maintain viable practices and keep them competitive in their market. One major issue will be how the College can provide guidance to evaluate our practices and the competitive landscape. Pathologists will need to adapt new technologies; the College should enable through education the ways that different practice types can adopt competitive technologies. The College needs to advocate for pathologists regarding the proposed changes in healthcare reimbursement. The College needs to continue current efforts to establish improvements in our core business that adds value to loyal customers. In addition, expanding core business opportunities to selected international markets will enhance revenue enabling additional program development to support members.

If elected, what do you hope to accomplish?

As described in previous answers, I will continue to work to connect academic and practicing pathologists to secure our future. We will translate modern science into clinical pathology practice securing our role as experts in diagnostic medicine and integral physician members of healthcare teams. Pathologists are the foundation of modern medicine enabling the efficient and effective treatment and management of patients.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Panel Candidate Profile

Candidate for Governor

Frank R. Rudy, MD, FCAP

Pinnacle Health System
Estero, Florida

Age: 66
Years in Practice: 35
Boards: AP/CP
Education: Received MD, 1974, University of Pittsburgh, Pittsburgh, Pennsylvania; Residency: Hospital of the University of Pennsylvania; Surgical Residency: Lankenau Hospital, Philadelphia, Pennsylvania

Employment Status: Retired
Practice Type: Hospital/Community Based Laboratory
Practice Size: 6-10

CAP Experience:

2015-present	Member, Complaints and Investigations Committee
2014-present	Member, Federal and State Affairs Committee
2014-present	Delegate, CAP House of Delegates
2010-2013	Chair, Commission on Laboratory Accreditation
2014 & 2008-2009	Advisor, Commission on Laboratory Accreditation
2012-2013	Vice Chair, Council on Accreditation
2010-2012	Member, Council on Accreditation
2008-2009	Advisor, Council on Accreditation
2009	Chair, Accreditation Committee
2006-2008	Member, Accreditation Committee
1996-2002	Regional Commissioner, Commission on Laboratory Accreditation

Experience in Other Organizations:
As the Chair of a not for profit mental health agency, I lead efforts to bring the agency back to financial solvency.

I served as the medical staff president (chief of staff) for two health care systems. During my tenure, I spearheaded the successful merger of three medical staffs, including the development of the medical staff structure and medical staff governing documents.

During my membership on a health system board, I was intimately involved in medical service and physical plant consolidation during the merger of two health care systems.

I reorganized the quality assurance and safely program for a large health care system during my chairmanship of the board committee that had oversight responsibility for the quality and safety of health care services.

Why do you want to be a governor or officer of the College?
For many years, I have been concerned about dwindling College financial reserves, and the continued reliance on reserves to cover operating expenses. Tens of millions of dollars of College reserve funds have been spent. At times, it appears the College has tried to be all things to all people, calling into question the ability of the organization to effectively prioritize projects and expenditures. The College was criticized in the past as a "mom and pop" organization, lacking the sophistication needed of a premier medical society. Since then the staff has significantly increased in size and the committee structure has expanded, leaving the College a more complicated and less nimble organization. I have a broad background, with 35 years of private practice pathology experience and extensive involvement in both the medical staff and board activities. I want to bring to the Board of Governors my knowledge of the problems of the practicing pathologist, my governance experience, and my understanding of the complex inter-relationship between College members and staff. I will use my experience to provide effective fiduciary and governance oversight to ensure that the CAP is the preeminent medical society, responsive to its members needs and successful in its mission.

What is the strongest contribution you could make to the CAP Board of Governors if you are elected?
The Board is ultimately responsible for the success or failure of the College and must critically examine and make sound judgments on recommendations coming from senior staff, councils and committees, and individual members. Based on years of experience as a medical staff president and health systems board member, I would come to the Board of Governors with a strong background in board governance and CEO and senior executive oversight. I have worked with six CEOs, numerous senior executives and consultants, and have experience with a wide range of management styles. In addition to my governance experience, I can effectively bridge the gap between members and staff in a complex organization such as the CAP.

What major issues do you see facing the College during the next three years?
1. Downward pressure on pathologist and laboratory reimbursement
2. Adapting to new payment models for health care delivery
3. Ensuring that pathology and pathologists are at the forefront of medical advances, embracing new and rapidely evolving technologies
4. Adapting to technologic changes that may alter how pathologists' and laboratory services are delivered
5. Attracting the best and brightest medical students to pathology
6. Working with other pathology organizations to make the MOC less onerous
7. Increased competition for laboratory accreditation and proficiency testing products, the financial engine of the College

If elected, what do you hope to accomplish?

1. Increased pathologist involvement in CAP advocacy efforts
2. Provide fiduciary and operational oversight leading to profits from operations
3. Increased revenues from the Laboratory Improvement Programs
4. Strengthen the relationship between the CAP and state pathology societies
5. Critically review staffing levels, executive compensation and executive goals

Delegate Issues

CONTENTS OF THIS SECTION

2015 Delegate Chairs Issues
Each year the Delegate Chairs are asked to canvas their delegations for issues of importance and delegate questions related to those issues. This section includes the information obtained in the reports we have received to date.

2013-2014 Delegates' Questions and CAP Answers
This information is also available on the HOD Discussion Board.

ICD-10 Information
This topic was identified at the Fall '14 House of Delegates meeting as being important to delegates in their practices. This section contains information available on cap.org on this topic.

State Pathology Societies
This topic has been identified as important to delegates. This section includes current information on CAP's relationships with state pathology societies.

2015 Delegate Chairs Issues

Each year the Delegate Chairs are asked to canvas their delegations for issues of importance and delegate questions related to those issues. This section includes the information obtained in the reports we have received to date.

State	HOD Delegate Chair	Description	Questions for CAP
Alabama	John A. Smith, MD, FCAP	Sent requests to delegates	
Arizona	Wenxin Zheng, MD, FCAP	LCDs Palmetto/Noridian	From CAP perspective, what are the guidelines regarding LCD process as outlined by Palmetto and Noridian?
Arizona	Wenxin Zheng, MD, FCAP	The MolDx LCD on special stains and IHC was finalized with minimal changes inWhat is CAP going to do next? Any plans more effective than token protests. the Palmetto region, despite CAP comments.	What is CAP going to do next? Any plans more effective than token protests?
Arizona	Wenxin Zheng, MD, FCAP	AZ pathologists find professional component of routine tests being sent out to tertiary labs located outside the state or a particular city in spite of local expertise available. These pertain esp. to GI, GU, GYN, and Derm practicees.	Can the CAP help the state pathology society draft a resolution which we could present to state medical society?
Arkansas	Jerad Gardner, MD, FCAP	Our state pathology society is defunct. Some of us in Arkansas would like to resurrect it but most of us have no idea of the technical details in starting/running a state society.	Can CAP give us guidance/support in getting our state society functional again?
California	S. Robert Freedman, MD, FCAP	I will be at the Spring HOD meeting next month and would like to continue as a Delegate. Regarding discussion topics, I don't know if it has been discussed yet, but there's been a lot of pushback by the internal medicine doctors regarding MOC; its value versus the amount of time and cost, etc. The same could be said for the pathology MOC and the ABP. Just because "everybody knows" that keeping current is beneficial for patient care, "nobody knows" what the most effective way to do this is. And as much as I trust Dr Johnson and the ABP to do the right thing, they do stand to benefit quite substantially the way this is set up. Just thought it could be something to talk about, and it's something I think is too important to relegate to a somewhat unwieldy discussion thread. Apparently the ABIM has significantly changed the way their MOC evaluation is done as a result of their members' pushback.	Is Maintenance of Certification necessary? What is the CAP doing to alleviate this requirement?
Connecticut	Robert Babkowski, MD, FCAP	CT Medicaid laboratory fee schedule for 2015, announced 1/2015, represents draconian cuts to all clinical labs in the state. Specifically, reimbursement for Gyn cytology is now the lowest in the country, and assures that no-one in the state will want to process and evaluate gyn cytology on the most at-risk population.	Can CAP allocate resources and work with CSP to amend/change the CT Medicaid fee schedule?

Connecticut	Robert Babkowski, MD, FCAP	Pathologists in CT, as rest of the country, are at risk of losing payment for PCCP from CIGNA. We would like a state law that would mandate that all insurers doing business in the state of CT have to pay hospital based pathologists something for laboratory management – either through PCCP or some fixed amount based on hospital bed-size.	Can CAP allocate resources and work with CSP to develop a strategy for introducing a state law to assure payment to hospital pathologists for laboratory management?
Connecticut	Robert Babkowski, MD, FCAP	End Stark Exemption. All pathologists in CT agree that TC-PC arrangements with urologists, dermatologists, gastroenterologists are fundamentally corrupt and undermine the profession and practice of pathology. The only way to end the abuse is to remove the ability for physicians to insource AP.	Can the CAP report on what its activities are to end Stark exemption for AP? How high is this on the CAP agenda list?
Connecticut	Robert Babkowski, MD, FCAP	ICD10 implementation will be disruptive to all pathologists (not to mention healthcare delivery in its entirety) and should be deferred indefinitely.	Can CAP report on its stance on ICD10? Is there pathologist unity on non-adoption on ICD10? How can CAP voice our collective displeasure on ICD10?
Connecticut	Robert Babkowski, MD, FCAP	ACO arrangements will ensure that pathologists will be working for free. Any cost savings through the work of pathologists(cost containment) will not result in revenue sharing with pathologists. To think otherwise is naïve. The only way pathologists will be paid in an ACO environment is if they receive payment for work done. This work has to be defined and monetary worth determined. The typical RVU model and Mcare time studies are useless in this, and a new way of calculating pathologists "worth" is needed.	Can CAP focus on defining work pathologists in hospital settings (and future ACOs)perform and determine value of this work? Can payment to pathologists in ACO world be based on hospital bed size, lab complexity, service demands? Can CAP develop "pathologist work units" that would serve as basis for ACO payment to pathologists for work done?
District of Columbia	Donald Karcher, MD, FCAP	Proposed FDA Oversight of Laboratory-Developed Tests: What is the CAP's position regarding proposed FDA oversight of laboratory-developed tests and how does the CAP's position compare to other pathology organizations' positions? As a member of the CAP CGPA and current President of the APC, I'm personally very knowledgeable on this issue and I've tried to keep DC delegation members informed. I think the HOD should help to keep members informed on this very important issue.	What is the CAP's position regarding proposed FDA oversight of laboratory-developed tests and how does the CAP's position compare to other pathology organizations' positions? I think the HOD should help to keep members informed on this very important issue.

Florida	Marino E. Leon, MD, FCAP	Code 88321 Consultation and report on referred slides prepared elsewhere. Code 88321 includes review of special stain, IHC, immunofluorescence, and other special procedure slides and test data prepared and initially interpreted at the referring facility. Special procedures can be separately charged if they are prepared or repeated by the lab at which the consultant practices. Cancer Centers review material from other institutions as a secondary review. This practice entails an additional effort. In many cases, the current CPT Code does not address the complexity and liability of this secondary review.	Cancer Centers review material from other institutions as a secondary review. This practice entails an additional effort. In many cases, the current CPT Code does not address the complexity and liability of this secondary review. What is the CAP doing to address this issue?
Georgia	Amyn Rojiani, MD, PhD, FCAP	No new issues to report	
Hawaii	James Navin, MD, FCAP	No new issues to report	
Idaho	Nancy Kois, MD, FCAP	No new issues to report	
Indiana	Michelle K. Zimmerman, MD, FCAP	We have heard that 88305 is the most frequently used CPT code used (not just for pathology, but all CPT codes). Consequently, 88305 has been targeted as 1. an overused/abused code or 2. a code for which reimbursement would be decreased.	code since not all 88305s are the same in time and effort ie a GI biopsy vs melanoma excision vs breast biopsy vs POCs vs TURPs having modifiers to distinguish them? Or mode codes available to categorize specimens besides 88300, 88302, 88304, 88305, 88307 and 88309—for all of the variety of specimens that taken from patients, that is not really a lot.
Indiana	Michelle K. Zimmerman, MD, FCAP	Our medical technologist force is aging and is at retirement age or nearing retirement within the next five years. However, that this field exists is not well known, even with all of those biology and chemistry majors out there in our colleges and universities.	What is CAP doing to help ASCP advertise the need and job opportunities for medical laboratory scientists? Being an MLS opens up doors not only in for a clinical lab job but also in research labs, IT, sales/support for manufacturers, etc.
Iowa	Jamie A. Weydert, MD, FCAP	Local coverage determination for pathology services by Regional Medicare Carriers.	Does the CAP have the ability to notify its members of adverse LCDs issued by Regional Medicare Carriers as they are proposed? Our state did not learn of WPS decision to not reimburse for essentially ALL 88342 (IHC) last year (under a flawed presumption by WPS) until the LCD went into effect. This lots of angst and back-billing headaches for essentially all of our practices until WPS fixed the issue. The CAP has been all over Palmetto, but we wonder if the same degree of surveillance is possible for all regional carriers?
Manitoba	M J Willard, MD, DVM, FCAP	Sent message to pathologists in Manitoba	

Massachusetts	Michael Misialek, MD, FCAP	Point of care glucose guidance	What guidance can CAP provide on compliance with off label use of glucose POC?
Massachusetts	Michael Misialek, MD, FCAP	Laboratory Developed Tests	What guidance can CAP provide on compliance with LDT regulation changes?
Massachusetts	Michael Misialek, MD, FCAP	Utilization - Delegate document does not have a practical roadmap.	What framework can CAP provide for approaches to utilization measures? How does the lab collaborate with clinicians in this regard? Electronic decision support? Limiting availability? Utilization feedback to certain groups?
Massachusetts	Michael Misialek, MD, FCAP	Molecular education	What does the community pathologist need to know for molecular?
Michigan	Vinod Shidham, MD, FCAP	Out of the country until March 2 - will work on providing	
Mississippi	James Almas, MD, FCAP	“Pathology Practice Guidances (PPG)”	What are the Pathology Practice Guidances results so far?
Mississippi	James Almas, MD, FCAP	“A test utilization work group was initiated in 2013”	What are the results of the test utilization work group that was initiated in 2013 so far?
Mississippi	James Almas, MD, FCAP	Indications For Special Stains	When is the College going to develop indications for special stains?
Mississippi	James Almas, MD, FCAP	Overutilization of IHCs	What is the College doing about over utilication of IHCs?
Mississippi	James Almas, MD, FCAP	Indications for ordering NGS	Does the College have guidance fpr ordering NGS?
Missouri	Jeffrey L. Craver, MD, FCAP	One concern would be the delicate political protocol of confronting hospital administrators, medical department heads, and quality review committees about dangerously incompetent clinical practitioners without risking retaliation.	Should Pathologists be the gatekeepers, or should we also observe the "code of silence" that seems universal in other physician specialties?
Missouri	Jeffrey L. Craver, MD, FCAP	The newly formatted CAP website has a clean crisp look, but some of us have problems navigating it. E.G., it used to be easy to find the current cancer synoptic protocols - now I use the Search tool. The LAP state commissioner assignment area and the calendar for committee meetings are two more examplese. Emailing results in no response regarding the calendar location.	Does the CAP have directions or a tutorial for how to get familiar with the new website? If not, would it consider developing one to benefit members?
New Hampshire	Candice Black, DO, FCAP	No new issues to report	
New York	Rana Samuel, MD, FCAP	Sent message to delegates	
Ohio	Debra Zynger, MD, FCAP	Sent message to delegates	
Oklahoma	Michelle L.E. Powers, MD, MBA, FCAP	No new issues to report	
Ontario	Terence J. Colgan, MD, FCAP	Our provincial negotiations for 500 lab docs have broken off, and the Ministry unilaterally imposed a 3% across the board cut.	What guidance and advice can CAP provice on how pathologists can be successful in today’s climate?

Ontario	Terence J. Colgan, MD, FCAP	There continues to be a push for system QA measures without requisite resources.	How to others deal with these changing expectatons in today's world?
Pennsylvania	Nancy Young, MD, FCAP	I would like to share a concern with you. There has been much discussion amongst physicians regarding Maintenance of Certification (MOC). While all physicians agree with the need for and commitment to continuing professional education and lifelong learning, MOC has become controversial. Many physicians view it as confusing, costly, time-consuming, and a poor method of demonstrating continued proficiency in one's specialty.	What is the College doing to make this a more reasonable process for its members?
Pennsylvania	Nancy Young, MD, FCAP	Synoptic Reports	Is the College doing anything to increase the RVUs and reimbursement for reporting using the CAP Cancer Protocol Templates?
South Carolina	Noel A. Brownlee, MD, PhD, FCAP	Most current status of legislation regarding in-office anatomic pathology laboratories	Is there any progress on ending the practice of in-office anatomic pathology laboratories in specialty practices such as gastroenterology and urology?
South Carolina	Noel A. Brownlee, MD, PhD, FCAP	Most current status on SGR Fix	What is the current status of legislation related to amending SGR formula?
South Carolina	Noel A. Brownlee, MD, PhD, FCAP	Most current changes in reimbursement for immunohistochemistry, flow cytometry, FISH and molecular pathology	Please discuss forecast for reimbursement for specialized testing methods.
South Carolina	Noel A. Brownlee, MD, PhD, FCAP	LCD ordering and payment for IHC and special stains	What is CAP's plan for addressing the statement issued by Palmetto GBA LCD concerning ordering and payment for IHC and special stains?
Tennessee	J. Cameron Hall, MD, FCAP	Insurance companies refusing to pay for the technical component (TC) of AP services, asserting that they have already paid for these services as part of a bundled payment to hospitals for the care of inpatients. Hospitals trying to pay for these TC services by using an improperly aligned payment scale.	How can CAP help struggling pathology groups effectively negotiate with insurance companies and/or hospitals to secure payment for performing the TC of AP services?
Tennessee	J. Cameron Hall, MD, FCAP	Insurance companies forcing pathology groups to accept payment for the professional component (PC) of AP services at rates below, sometimes markedly below, Medicare rates.	Can CAP avert the practice of insurance companies forcing pathology groups to accept payment for the PC of AP services at rates below Medicare rates? Is this practice an organized strategy by insurance companies to shrink the number of pathologists with whom they have to contract?
Tennessee	J. Cameron Hall, MD, FCAP	With implementation of ICD-10 looming, many groups are very anxious about how to best prepare for this major change in its workflow and billing procedures.	Will CAP be further developing an organized strategy for helping pathology groups transition to the ICD-10 coding system?

Tennessee	J. Cameron Hall, MD, FCAP	As ACOs are being developed and launched, pathology groups need continuing support from CAP to ensure that groups are participants in and are important contributors to these ACOs.	How will CAP continue to support pathologists to help them be participants in and important contributors to ACOs?
Tennessee	J. Cameron Hall, MD, FCAP	FDA will announce changes in regulation of LDTs soon. How these changes will impact pathology as a profession may be significant.	What is CAP's plan for preparing the membership to respond to the FDA changes for the regulation of Laboratory Developed Tests (LDTs)? How does CAP anticipate that these changes will impact pathology?
Texas	Rodolfo Laucirica, MD, FCAP	Sent message to delegates to respond to JG or RL	
Utah	Dylan Miller, MD, FCAP	No new issues to report	
Virginia	Elizabeth Martin, MD, FCAP	Palmetto Local Coverage Determination Policy	Can you update us on the CAP action plan to respond to the Palmetto LCD?

COLLEGE of AMERICAN PATHOLOGISTS

2013-2014 Delegates' Questions and CAP Answers

This information is also available on the HOD Discussion Board.

Fall 2014 House of Delegates – Delegate Questions

During the Fall '14 meeting, Delegates were asked to post their questions and discussion on the CAP House of Delegates' online collaboration space following the meeting. Those posts follow:

1. **ICD – 10** – no questions or replies

2. **Licensure of laboratory personnel** – no questions or replies

3. **Autopsy data and DRG reimbursement**

    a. Reimbursement for Autopsies is an important (issue), and often forgotten area which should not be forgotten in CAP's advocacy efforts. – Posted by Martha R Clarke at September 17, 2014

    b. Everyone in the pathology community agrees that autopsy is important and both the professional and technical efforts should be compensated appropriately. Although medicare claims that it covers autopsy as overhead payments to the hospital in part A, the amount is not specified, neither is it tied to the level of efforts or whether an autopsy is actually performed. As far as I know, there is no direct reimbursement from either governmental or private insurers. I wonder whether anyone in the college has successfully negotiated reimbursement for autopsy service from any insurers, what is the college's position, and whether there is any ongoing or planned effort by the college to obtain direct reimbursement. – Posted by Zhaohai Yang at September 22, 2014

    c. *The following post is from Governor and Vice Chair of Council on Government and Professional Affairs, Emily Volk MD, FCAP.*

    Certainly, as a pathologist, I value the insights that an autopsy can bring to the understanding of a patient's disease and the manner in which they died. Unfortunately, as the HOD member points out, this is a service that is not directly reimbursable by CMS as the service is rendered after a patient's demise, by necessity, of course. That being said, I believe that pathologists should be appropriately reimbursed for the work we do and the value we add. Our pathology group has been successful in securing reimbursement for autopsies performed on hospital patients that the hospital has requested for purposes of risk management or quality assurance. We also available to the families of the deceased hospital patients a private autopsy fee schedule that spans the range of services from single organ evaluation to complete autopsy to include examination of the brain and spinal cord. We find that on occasions families are willing to pay for this valuable service, even if the hospital team does not find the autopsy necessary for risk management or quality review purposes.

    I hope you find this input helpful.

    Sincerely,

    Emily Volk, MD
    Member, Board of Governors
    Vice-Chairman, CAP Council on Government and Professional Affairs

4. **Test Utilization – Over/Under/Mis-Utilization**

    a. Comments articulated during the New Business segment of the fall House of Delegates meeting suggest that our members would like the College to develop and maintain practice guidelines on ordering special and immunohistochemical stains. Does the College plan to address this need? – Posted by David Alan Novis at September 16, 2014

b. I am hoping that CAP and the House will appreciate that utilization recommendations from the College must be nuanced.

In a few circumstances there is strong scientific evidence that it is necessary to order a procedure (such as an immunoperoxidase stain) or strong scientific evidence that ordering the procedure is inappropriate. The risk/cost/benefit equation tilts overwhelmingly in one direction. In these circumstances, CAP might issue a guideline from the Center or incorporate the conclusion into a laboratory accreditation checklist. But most circumstances aren't this clear-cut.

In most cases, context is king. An immunoperoxidase study that might be indicated in an otherwise healthy 40 year old might not be appropriate in a 85 year old in hospice dying of metastatic disease. Medical judgement is required -- a weighing of benefits, costs, risks and values for a particular patient. In these circumstances, it is difficult for the College to weigh in, lest it interfere with local medical judgement. At best, the College might list factors a pathologist may wish to consider, or provide a repository of "guidelines" from submitters who have personal views, without making any suggestion that the College supports one or another submitted guideline.

I recognize that what concerns many members are laboratories that routinely perform special procedures regardless of clinical circumstances. The is a perception that this "overuse" is leading to a reduction of reimbursement by insurers. And well it may be. Even here, however, the situation is nuanced. What is the "correct" laboratory response when a gastroenterology group, considering costs and benefits and risk, determines that it wants special Helicobacter studies on all gastric biopsies? Is the laboratory violating some sort of laboratory standard by accommodating this request? Perhaps the issue is with the gastroenterology group and standards for gastroenterologists? Or perhaps the gastroenterology group's thinking is reasonable from a medical standpoint, even though it is costly. Perhaps a narrow-network insurer will exclude the gastroenterology group from its panel of providers on the basis of cost, but that neither the laboratory nor the gastroenterology community will consider the practice to be "wrong" from the perspective of patient risk and benefit.

The bottom line is that it is important to be careful with guidelines and standards. In a few cases, the scientific evidence is clear. But in most cases there is considerable subtlety. – Posted by Paul N. Valenstein at September 19, 2014

c. Thank you Paul for your comments, insightful as they always are.

So what in life isn't nuanced?

Sure, context is king. And judgment is *always* required in decision making, medical or otherwise. But I am not seeing the leap from those considerations to assuming that the College would propose guidelines that interfere with local medical practice. I think House Delegates understand the requirement that guidelines be based on scientific evidence, that conclusions are not possible in situations where no evidence exists, and that recommendations incorporate caveats--as they always do--to allow for the uncertain, meandering paths traveled by diseases and cures.

But none of that exonerates the Board of Governors from addressing an account that our member constituents believe to be past due. You provide penetrating and difficult questions that your peers on the Board of Governors will need answer in deciding how they will respond. It is not the House's job to direct or second-guess the Board in that process, but rather to evaluate whether or not the outcome of that process meets their needs.

Good luck. - Posted by David Alan Novis at September 19, 2014

d. As Chair of the Center Committee, I'd like to share that the Center partnered with the HOD in 2013 on an Action Group for Center Guideline Submission Ideas. Three of the 11 ideas submitted by the HOD Action Group were selected for the prioritization process. One of the ideas provided by the HOD, Utility and Cost-Effectiveness of *H.pylori* Immunostains vs Special Stains is currently in development and is among

our first Pathology Practice Guidances (PPG). This PPG is targeted to be available for review during an open comment period in late Q4 of 2014. I encourage all interested House members to participate in the brief survey during the open comment period for this PPG. Additionally, we are working with a separate HOD Action Group to evaluate other PPGs in development.

I also serve as the Chair of the Test Utilization Workgroup which was launched in November 2012, by the Council on Scientific Affairs (CSA). The working group now comprises 13 pathologist members from throughout the United States with expertise in test utilization. The purpose of this workgroup is to explore best practices and develop recommendations regarding test utilization. The strategy behind this process is not only to educate clinical colleagues of unnecessary and medically unjustified tests, but to educate them in offering the right test at the right time for the right patient. The activities being developed in coordination with other committees will result in reduced hospital stay and eventually help reduce healthcare costs. I invite my fellow Committee and Council Chairs to share with delegates those initiatives that are underway at their institutions. - Posted by Elizabeth A. Wagar at September 24, 2014

e. Liz, in my view it appears that you are addressing the need expressed by Delegates at the HOD meeting. Best of luck in your efforts. – Posted by Dave Novis at September 24, 2014

f. I would like to thank Dr. Liz Wagar for her leadership in the area of test utilization, including anatomic pathology utilization of immunohistochemical stains, with the issue of H. pylori staining being among the first three PPG's the Center will publish.

The Council on Scientific Affairs is deeply involved in several areas concerning test Utilization. At the direction of the Council on Scientific Affairs, a test utilization work group was initiated in 2013 that, as she notes above, is comprised of 13 members with expertise in test utilization at their institutions. Dr. Wagar is the Chair of that group. This group created a preliminary needs assessment survey that was sent to 900 CAP fellows. Based on the feedback, the questionnaire is now being finalized to be sent to ALL proficiency testing laboratories. The data will help create a baseline for future investigations and recommendations to clinical laboratories, and would result in a publication in the Archives of Pathology and Laboratory Medicine.

Next, the Quality Practices Committee is in the process of examining how they can help elucidate current test utilization practices of our members. The committee plans to evaluate a process for our members to participate in this project and effectively use the data generated by it.

Additionally, CAP is collaborating with the Clinical and Laboratory Standards Institute (CLSI) on a joint publication on how to effectively develop and operate a test utilization committee. This report is expected to take about a year and a half to complete. For this collaboration, both CAP and CLSI will co-chair the committee with Dr Gary Procop being the co-chair for the College.

Our President, Dr. Gene Herbek is taking the lead on this issue and has scheduled a discussion of this issue at the next Board of Governors Executive Committee meeting.

Finally, I have put this issue on the agenda for the next CSA meeting, to be held in November. The CSA will review the above three initiatives and consider if there are other appropriate actions that could be taken in this area.

I appreciate the HOD bringing its concerns to the attention of the BOG and the various councils and committees involved with this issue. In addition to the projects already underway in this area, the College will continue to review this subject and others that are of importance to all of our members. – Posted by R. Bruce Williams, Chair CSA at September 24, 2014

g. Hello All,

I'm thankful for the chance to discuss this topic further and am a little saddened that more people are not here discussing it (especially given the urgency that some attendees of the house expressed).

I'm also very happy to see the H. Pylori work being done and look forward to the report. I know that there are more PPGs in the works (and hope to help in their development), and maybe these will help in numerous other situations.

All that being said, I think most over-utilization is done very consciously - either by those who want to make more money or those who are worried about litigation. I feel like neither of those approaches will be swayed by guidelines from the CAP and such guidelines would only serve as fodder for lawyers and/or CMS / Insurance companies.

As New-In-Practice pathologist I may use more immunos that my colleagues, but if you look at the actual numbers it's really just a small amount - i.e. in general NIP pathologists are not the problem. Also, in Academics IHC is more utilized that in private practice, so the perceived over-use of a NIP pathologist may be more in how we were trained rather than true over-usage (Ex. Spindle cell lesion in the GI tract....looks just like a Leiomyoma, but a very senior and fantastic pathologist taught me at UPenn to get an SMA just to make sure I'm not missing a GIST. So, I may get 1 stain where my senior peers would not. The difference is I won't get the whole panel on a case, just 1 confirmatory stain...and if that doesn't work out I'd move on from there.)

So ultimately, the job lays on the pathologist themselves to know what is proper and appropriate with a huge onus on the training programs to ensure that we know what is required, what is nice to have, and what is just academic endeavor.

If/When guidelines are made, I hope there are more conceptual rather than prescriptive, again to provide for pathologists in need, not lawyers / CMS with ammunition. - Posted by Nicole D Riddle at September 25. 2014

h. Thank you to all who have shared in this thread.

Expertise in utilization is perhaps our greatest talent with which we can demonstrate value to our clinical colleagues, healthcare administrators, policy-makers and the public. We have many stories to tell, as evidenced by an almost monthly article in CAP Today on another success (check out the current cover). Clearly a lot of work has been done.

However, as with any emerging concept, there is a spectrum of experience to draw upon. It is communication that serves to connect us all so that we can learn from each other. It is action that puts this innovation into effect.

The HOD represents an immense talent pool that spans all practice types. Let’s use this space to constructively debate the issues and connect with each other and the Board. What do you need from the College? What do you want to tell the Board? Importantly, let’s share our stories. - Posted by Michael John Misialek at September 25. 2014

i. I agree that our communication to the public on this matter needs to be nuanced. However, as this discussion is among colleagues I think it would be valuable to take the opportunity to be more frank.

Does pathology test over utilization exist? Yes.

Is it appropriate to order a special stain on every gastric case? It seems to me very unlikely that any study will demonstrate the cost effectiveness of this practice (except for the laboratory performing the stain).

Is it reasonable to consider guidelines regarding the use of special stains on routine biopsies. I think so.

I am curious to hear the reasoning behind the CAP's request to have Palmetto remove the article on the use special stains on gastric biopsies. I am also curious to hear the position of our own test utilization committee on this subject. - Posted by Emily Ann Green at September 25. 2014

j. I trust our esteemed colleagues serving on the Center Committee and the CSA to approach this topic with the stepwise caution and thoughtful analysis characteristic of their work to date. The open comment period will further assure that nuances and differing perspectives are considered. I will look forward to the draft products with great interest and do my best to add whatever my own experience has taught me, because I believe that together we will do this better than any one of us could do alone. - Posted by Patricia A Gregg at September 25. 2014

k. I am thrilled to see that this conversation thread is generating traction. Let me try to be both nuanced and frank.

I do not believe that the scientific method will help us with most practical utilization problems. Any definition of "appropriate" or "inappropriate" utilization involves a value statement, and science tries its best to steer clear of values. There are a few instances when the scientific evidence strongly suggests that some type of testing is "appropriate" or "inappropriate", which is to say that when we combine scientific facts with any reasonable value system the arrows all point in the same direction -- something is clearly good or is clearly bad.

Yet most of the utilization issues we are asked to consider fall between these two extremes. Different value systems lead to different conclusions. A well-meaning physician only concerned with a patient's health will come to a different conclusion from a well-meaning physician who also considers the patient's pocketbook and perhaps the pocketbooks of institutions and society.

Let me illustrate with a real example:

In my particular practice (16 pathologists), we consider cost as well as medical benefit and risk when deciding what to do, and would never order special stains for Helicobacter routinely on every gastric biopsy. We figure the cost to detect an additional case of H. pylori (compared to selective use of special stains) is about $30,000 per extra case detected, which is too rich for us.

But I know a physician who considers herself to be pure a patient advocate – she only considers the patient's medical benefit and medical risks when making a decision. She doesn't consider charges or co-pays or societal cost. She doesn't believe that is her role. She has a different value system, and as a result, she drew a different conclusion about H. pylori staining with the same set of facts. She reasoned that there is almost no patient risk to performing a special stain routinely, and there is some incremental benefit. It is easy for me to say that this physician orders all these special stains because she wants to earn more money, but the fact of the matter is that she is salaried and derived no economic benefit from ordering these stains. She genuinely thought it was the right thing to do, given her view of the physician-patient relationship.

Without agreement about values, science can't tell us what to do – what represents "overutilization" or "underutilization".

Still, there is much CAP can contribute in this area. I hope the CAP provides guidelines and standards when the evidence points in one direction under any reasonable value system.

For most issues, CAP can inform practices and members by providing information about observed or modeled outcomes of various testing strategies. This can be done without any agreement about values.

I am not sure I would want to live in a world where everyone had the same values. That would be a creepy place, although it would be easier to write guidelines in such a world. - Posted by Paul N. Valenstein at September 25. 2014

l. This is an excellent, and very much needed discussion. Elsewhere on the net, pathologists are forcefully (and at times, not very productively) expressing their opinions about these matters and it would be nice to bring as many (constructive) opinions as possible from the general membership to this discussion site. Unfortunately, it seems that the site is restricted to HOD and board members only. Is there anyway to open up specific discussion sites to the general membership in order to provide all of our colleagues an

opportunity to participate? Thank you all for your hard work and great input. - Posted by Karim E Sirgi at September 25. 2014

m. It *is* possible to create best practice guidelines for surgical pathology.
In the recent article from the International Society of Urologic Pathology consensus conference regarding immunohistochemistry use in prostate core biopsies, the following straightforward guidelines were given: "In the setting of obvious carcinoma or benign glands, there is no justification to do basal cell stains and AMACR. If there is a Gleason score of 3+4=7 or a higher-grade cancer on at least 1 part, the workup of other parts with an atypical focus suspicious for Gleason score 3+3=6 cancer is not recommended." (Am J Surg Pathol. 2014 Aug;38(8):e6-e19).

It is important to realize that other medical societies do have best practice guidelines. Here is a link from the American Urologic Association website with numerous clinical practice guidelines and best practice statements (http://www.auanet.org/education/aua-guidelines.cfm). These types of guidelines help ensure that patients receive adequate care and can be used by insurance payers to determine if the care given was standard of care.

In order to contain pathology healthcare costs and reign in overuse and abuse, we need to focus on high volume and/or high expense waste rather than rare instances that have been brought up on this blog such as ordering 1 immunostain more for a spindle cell lesion.

I would like the discussion to not only include the high volume low costs special stains and immunohistochemistry, but also to address high cost send out molecular tests such as Foundation One, Oncotype DX, Prolaris, Caris, Tissue of Origin, RedPath, etc. Many of these tests are in the $3000-$5000 range and at my institution there has been a dramatic increase in ordering. Of note, many of these tests are not FDA approved—there is little oversight regarding the claims made for these tests. The Evaluation of Genomics in Practice and Prevention (EGAPP) Working Group "found no evidence regarding the clinical utility of the MammaPrint and Quest H:I Ratio tests and inadequate evidence regarding Oncotype DX." (Genet Med. 2009 Jan;11(1):66-73.). At CAP 2014, in the plenary addressing if we could afford to pay for molecular medicine it was disappointing that the response was a casual, sure, rather than a detailed discussion regarding the need for carefully evaluating expensive molecular tests that have the potential to do harm.

Some hospitals have "lab formularies" or "meaningful use" committees which evaluate the level of evidence for the use of these high cost send out tests which are performed on surgical pathology specimens. These committees investigate whether there are less expensive or better tests available. My hospital does not have this. Although there might not be evidence to order these tests and pathologists may not want to send out the tissue, some of us really have little choice. CAP could help educate us on the utility/lack of utility of these tests. The CAP website could present balanced and up to date information. The CAP could make formal evaluation of the clinical utility of send out tests performed on anatomic pathology specimens a requirement for AP lab accreditation beginning with a phase 0 deficiency. This way labs could slowly create the infrastructure needed to evaluate the tests.

Creating guidelines and educating pathologists on appropriate testing would allow pathologists to make a meaningful contribution to our clinical colleagues and our patients and would help control healthcare costs. This would be a truly transformation role. - Posted by Debra Lyn Zynger at October 05. 2014

n. Debra makes a number of good suggestions about how to manage utilization in pathology and laboratory medicine. Some interventions - such as the adoption of test formularies and on-line real-time feedback at the time of order entry - have significant potential to curb inappropriate utilization.

CAP is already involved in some of these areas, and could do much more if our organization can develop the right model to sustain these efforts. As the CAP Secretary-Treasurer, I have come to appreciate the hard work that is required to sustain College activities. Successful programs generally require a revenue model to cover some of their costs, rely on member-volunteers to keep costs down and to make sure the output is clinically relevant, and must provide some sort of non-economic compensation to members for contributing -- status, academic advancement, or the simple gratification of doing good work and making

a difference. We should challenge ourselves to think about how to involve the College in the utilization management sphere in a sustainable way. The societal benefit from these activities can substantial.

Let me turn our attention back to guidelines and standards. I have maintained in this space that most guidelines and standards contain embedded value statements that patients and large elements of society may not share. As such, their value in utilization management is limited. Guidelines and standards work best when scientific data, combined with any reasonable value system, points in one direction -- some intervention is clearly a "plus" or a "minus". But most situations are not clear cut.

Debra referenced guidelines developed by the American Urological Association (AUA). So let's turn to a guideline developed by the AUA on early detection of prostate cancer:
http://www.auanet.org/education/guidelines/prostate-cancer-detection.cfm

Anyone who thinks that the AUA is going to be promulgating shrill, biased guidelines is going to be utterly disappointed. This guideline is thoughtful and thorough.

I would encourage participants in this conversation thread to read this lengthy guideline and think about the values that underpin the recommendations. Try listing some of them, and asking yourself whether all patients, the medical community, and the most segments of society share these values.

I would also encourage readers to ask themselves what value the guideline is providing in areas where the authors acknowledge that the best course of action depends on an individual patient's values.

If you don't want to read the entire guideline, at least ask yourself these questions:

i. The guideline about screening does not consider societal cost. The implicit value-statement made by this omission is that the role of physicians is to consider medical benefit and medical risk, but not to consider the cost to society. Do you share that view? If the guideline did consider societal cost, would you object?
ii. For the age group 55 - 69, the guideline recommends "shared decision making" by patient and physician about prostate cancer screening. This recommendation follows from the recognition that the rational course of action in this age group hinges on a patient's values -- what an individual patient thinks about the potential 1 in 1,000 chance of having his life extended vs the morbidity that follows from a PSA-based screening program. For this age group, is this recommendation much of a guideline? Isn't shared decision-making the norm? What is being added, beyond the summarized data about benefits and risks?

I found the AUA guideline on early prostate cancer detection to be well done and to provide a wealth of information that can be useful to patients and physicians contemplating options. I hope the College continues to issue guidelines in areas where there is well-developed clinical data. But the AUA paper also underscores the limitations of guidelines as a utilization management tool.

The College, in my view, should not pin its utilization management efforts on guidelines. - Posted by Paul N. Valenstein at October 06. 2014

Previously Submitted Delegate Questions

1. What role will CAP have in ACOs?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
CAP's role is to help prepare pathologists for participation in ACOs and other evolving payment models by providing information and tools to help pathologists understand and manage the different coordinated care models and their role in them. CAP's role is also to increase the visibility and promote pathologists in these models. HOD delegates can find examples of these resources and tools on ACO/Coordinated Care online resource center updated regularly on CAP's website. CGPA is pleased to provide an update to the HOD as ACOs and the efforts of CAP and its members continue to develop.

Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014
July / August 2013

ACO Resource Center

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Original Answer provided July 2013 by Council on Government & Professional Affairs:

CAP's role is to help prepare pathologists for participation in ACOs and other evolving payment programs by providing information and tools to help pathologists understand and manage the different coordinated care models and their role in them. CAP's role is also to increase the visibility and promote pathologists in these models. HOD delegates can find examples of these resources and tools on CAP's website including the ACO/Coordinated Care online resource center; Policy Roundtable White paper; and Promising Practice Pathways. CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Please see CGPA's response to HOD Delegate questions in 2012 on ACOs.
The following links are also provided as background information:
CAP's ACO Resource Center
CAP's ACO Resource Center
CAP's ACO White Paper
ACO FAQs
2012 ACO Summit

2. How will the CAP support the inclusion of a pathologist on ACO boards?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
The College is working on legislation at the state level to help integrate and promote the role of pathologists within ACOs. It is the College's belief that pathologists add medical value to an ACO's clinical decision making process. In 2012, the college, in collaboration with the Massachusetts Society of Pathologists, advocated on a bill, which was enacted into law, that promoted the role of CLIA medical director within ACOs. Subsequently, the college continues its work with several state societies to introduce legislation similar to that in Massachusetts to require ACOs in that state to establish a Clinical Laboratory Testing Advisory Board to make recommendations to an ACO on guidelines or protocols for clinical laboratory testing. The board would be required to include at least one physician, affiliated with the ACO and is a medical director of a laboratory regulated under CLIA. CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Statline: ACO Roles Gains Patient Supporters

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Original Answer provided July 2013 by Council on Government & Professional Affairs:
The College is working on legislation at the state level to help integrate and promote the role of pathologists within ACOs. It is the College's belief that pathologists add medical value to an ACO's clinical decision making process. In 2012, the college, in collaboration with the Massachusetts Society of Pathologists, advocated on a bill, which was enacted into law, that promoted the role of CLIA medical director within ACOs. Subsequently, the college continues its work with several state societies to introduce legislation similar to that in Massachusetts to require ACOs in that state to establish a Clinical Laboratory Testing Advisory Board to make recommendations to an ACO on guidelines or protocols for clinical laboratory testing. The board would be required to include at least one physician, affiliated with

the ACO and is a medical director of a laboratory regulated under CLIA. CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Statline 2-28-13
Please see CGPA's January and February 2013 Report to HOD Members
(i.e. CAP Model ACO Legislation Introduced in California and Illinois) CGPA Reports

3. Will the CAP prepare pathologists for ACOs, and departure from fee-for-service payment?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
Yes, CAP will help prepare pathologists for participation in ACOs and other evolving payment models by providing information and tools to help pathologists understand and manage the coordinated care and other models and their role in them.

Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014
July / August 2013

Examples of some of these resources and tools and other information provided to keep CAP members apprised of developments include:
ACO Resource Center

Statline
Medicare ACOs Expand
Policy Meeting Speaker

CAP's ACO Network – Open to CAP members who work in facilities that are currently, or will be, part of an ACO - email us. Members who are part of the CAP ACO network also may join its CAPconnect (members only) group at http://community.cap.org/groups/cap-aco-network-members-only/
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Original Answer provided July 2013 by Council on Government & Professional Affairs:
Yes, CAP will help prepare pathologists for participation in ACOs and other evolving payment programs by providing information and tools to help pathologists understand and manage the different coordinated care models and their role in them.

Examples of some of these resources and tools include:
- CAP ACO/Coordinated Care online resource center on CAP's website CAP's ACO Resource Center
- Coordinating advocacy efforts with state pathology societies
- ACO panel discussion at CAP's 2013 Policy Meeting
- CAP's ACO Network
- CAP's Promising Practice Pathways
- CAP's Policy Roundtable White paper: Contributions of Pathologists in Accountable Care Organizations: A Case Study (Shares findings from CAPs case study of three ACOs where pathologists have taken leadership roles).

CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Please see CGPA's response to HOD Delegate questions in 2012 on ACOs.
The following links also provide background information:

CAP's ACO Resource Center

CAP's ACO White Paper
ACO FAQs
2012 ACO Summit

4. Will the CAP assist pathologists in obtaining 3rd party payment for clinical pathology services?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
Yes, this year, CAP advocated aggressively with Cigna to retract its intended policy under which the professional component of clinical pathology would have been denied effective March 10, 2014. In early February, Cigna announced it would not proceed with implementation of its policy, as planned. CAP kept members notified of its efforts via special Statline alerts and other means. Through its legal advocacy program, the College also supports professional component billing as one valid method of billing by pathologists for their clinical pathology services. CAP supported pathologists in Illinois in the Neighborhoods Clinics LLC v. Pathology CHP S.C., et al., and submitted an amicus brief in support of the Illinois pathologist's request for summary judgment. This is an active issue at the local level through CAP's legal advocacy program. The CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014

PC Information Page
Regulatory Resources
CAP Policy CP Billing
Statline: CAP Opposes Cigna
Statline: Cigna Abandon Plan to Deny Payment
Statline: Cigna Delays PC Billing Policy
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Original Answer provided July 2013 by Council on Government & Professional Affairs:
Through its legal advocacy program, the College supports professional component billing as one valid method of billing by pathologists for their clinical pathology services. CAP supported pathologists in Illinois in the Neighborhoods Clinics LLC v. Pathology CHP S.C., et al., and submitted an amicus brief in support of the Illinois pathologist's request for summary judgment. This is an active issue at the local level through CAP's legal advocacy program. The CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Part A Information

5. What are the CAPs efforts in ensuring fair payment for current and future CPT codes? How does the CAP determine and validate recommendations to CMS on CPT payment levels?

Recommendations for professional payment is collected through a survey process which collects individual pathologists responses.

To obtain the necessary updated TC data, The direct input data requires itemized collection of clinical labor time, medical equipment and medical supplies on a code-by-code basis.

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:

In general, new and revalued CPT codes for physician fee schedule services are valued through the AMA/Specialty Society RVS Update Committee (RUC) process and are then submitted to CMS for consideration. CAP is involved in the process as the primary specialty representing pathology and it includes the following:

- CAP coordinates with other pathology societies the collection of data used to develop recommended values to the RUC.
- The survey data represents individual pathologists' responses received from each society's membership on a code by code basis.
- CAP submits recommendations to the RUC for physician work, practice expense inputs and professional liability insurance (PLI) crosswalks.
- Recommendations are presented at the RUC meetings which occur three times a year.
- The RUC sends its recommendations for work values, practice expense inputs and PLI crosswalks to CMS which are confidential until CMS publication.
- CMS can accept, modify, or reject any recommended value submitted by the RUC.
- CMS publishes their determination in final fee schedule by Nov. 1 of each year.

Throughout this process, CAP seeks to best protect and mitigate any potential payment losses to pathology. CMS continues to target services considered overvalued from pathology and other specialties. CAP is currently engaged through its role in the CPT, RUC and with CMS to protect the interests of pathology. Targeted services includes the following:

88305 TC ***UPDATED***
CMS questioned the typical number of blocks for TC from the valuation process that resulted in 2013 cuts, and asked RUC to validate. CAP collected data from multiple societies, which validated previous assumptions. At stake: CMS threat for additional 25% cut in 2014 if typical blocks per 88305 are rejected. CAP successfully defended its block study assumptions and efforts by CMS to further cut the global and technical component of surgical pathology codes 88300-88309 Based on the input received, no further cuts in the cost data were taken for 2014.

Enhanced Cytology (88112) ***UPDATED***

- CMS targeted 88112 as overvalued in 2011 due to the increased volume and change in use of the service.
- CPT code 88112 represents the highest volume cytopathology code with utilization doubling since the code was established in 2004.
- Reductions in payment were anticipated as the use for the codes first valued in 2003 has changed.
- Mandated review of professional and technical components is first in 10 years
- Last valued as new service; typically value goes down as technology becomes widespread. Reductions based on RUC review were implemented in 2014.

In Situ Hybridization ***UPDATED***
The current FISH codes (88365-88368) allow for multiple units of each code to be billed per slide. CMS expressed concern regarding the current reimbursement which prompted CAP to recommend revisions to the code set to preserve payment for multiple probes by establishing new codes for each additional probe. CAP anticipates CMS will adopt PC values representing reductions in 2015 based on RUC review. However, due to concern regarding the current payment, the agency included limiting National Correct Coding Initiative Policy Manual language for 2014.

Microdissection ***UPDATED***

- Medicare is questioning paying pathologists separately for microdissection together with molecular pathology services due to concerns with the current RUC valuation.
- Pathologists are at risk for losing this physician service as Medicare is considering bundling the payment for microdissection together with payment for molecular pathology.
- Efforts to revalue the service may result in lower reimbursement; however, revaluation may prevent efforts to bundle and deny payment.
- Changes in reimbursement anticipated in 2015

CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014
November / December 2013
September/October 2013
July / August 2013

Medicare 2014 PFS Resource Center

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Original Answer provided July 2013 by Council on Government & Professional Affairs:
In general, new CPT codes and revalued CPT codes go through the RUC process and are then submitted to CMS for consideration. CAP is involved in the process as the primary specialty representing pathology and it includes the following:

- CAP coordinates process for respective physicians distributes work surveys to members to obtain work & practice expense data.
- CAP submits recommendations to the RUC for physician work, practice expense inputs and professional liability insurance (PLI) crosswalks.
- Recommendations are presented at the RUC meetings which occur three times a year.
- The RUC sends its recommendations for work values, practice expense inputs and PLI crosswalks to CMS which are confidential until CMS publication.
- CMS publishes their determination in final fee schedule by Nov. 1 of each year.

Throughout this process, CAP seeks to best protect and mitigate any potential payment losses to pathology. CMS continues to target services considered overvalued from pathology and other specialties. CAP is currently engaged through its role in the CPT, RUC and with CMS to protect the interests of pathology. Targeted services includes the following:

88305 TC

- CMS questioned the typical number of blocks for TC from the valuation process that resulted in 2013 cuts, and asked RUC to validate.
- CAP collected data from multiple societies which validated previous assumptions.
- At stake: CMS threat for additional 25% cut in 2014 if typical blocks per 88305 is rejected.
- CMS will have final say on RUC recommendations in Nov. on 2014 physician final rule.

Enhanced Cytology (88112)

- CMS targeted 88112 as overvalued in 2011 due to the increased volume and change in use of the service.
- CPT code 88112 represents the highest volume cytopathology code with utilization doubling since the code was established in 2004.
- Reductions in payment anticipated for 2014
  - Mandated review of professional and technical components is first in 10 years
  - Last valued as new service; typically value goes down as technology becomes widespread.

In Situ Hybridization

- CMS targeted the current payment structure which allows for billing by probe for in situ hybridization.
- Also, FISH services for urine specimens are not paid per probe but on a sliding scale, causing additional scrutiny to the current per probe payment model for in situ hybridization as stakeholders representing urology groups have complained to CMS, prompting the PC and TC revaluation.

Immunohistochemistry (Code 88342)

- 88432 payment represents the second highest volume pathology service and is expected to decrease in 2014. CMS identified CPT code 88342 in 2011 as a high volume code that had not been reviewed.
- CAP implemented a strategy to mitigate reductions and to best preserve payment for the first use of the code in 2012; however, interpretation of multiple stains are expected to see reduced payments.

Microdissection

- Medicare is questioning paying pathologists separately for microdissection together with molecular pathology services due to concerns with the current RUC valuation.
- Pathologists are at risk for losing this physician service as Medicare is considering bundling the payment for microdissection together with payment for molecular pathology.
- Efforts to revalue the service may result in lower reimbursement; however, revaluation may prevent efforts to bundle and deny payment.

CGPA is pleased to provide an update to the HOD as this issue continues to develop.
Background Information:
Please see CGPA's March and April 2013 Report to HOD Members; (i.e. CAP Comments on Federal Payment Reform Efforts) CGPA Reports
Please see CGPA's January and February 2013 Report to HOD Members
(i.e. CMS Issues Guidance on Sequestration; Threat to Core Pathology Services Continues)

Please see CGPA's November/ December 2012 Report to HOD Members
(i.e. 2013 Medicare Physician Fee Schedule)

Please see CGPA's September/October 2012 Report to HOD Members
(i.e. Proposed Physician Fee Schedule)

Medicare 2013 Physician Fee Schedule Resource
The following Statline Articles also provide background information:
January 2, 2013
January 2, 2013
November 5, 2012

6. What is the CAP position on competition among pathologists, e.g. pathologists practicing in national multispecialty commercial labs or those practicing in physician self-referral labs competing with those practicing in small community hospitals?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
The CAP advocates closing the loophole for anatomic pathology in the "in-office ancillary services" (IOAS) exception to the federal Stark physician self-referral prohibition. The CAP believes self-referral arrangements for certain services, including Anatomic Pathology (AP), provides an incentive to over utilize services that increases health care costs with no benefit to patients. CAP supports legislation introduced in the U.S. House of Representatives (H.R. 2914) to close the IOAS exception for certain services including AP. CAP also supports using the savings created from closing the loophole to help pay for legislation that repeals the Sustainable Growth Rate. The CAP is actively lobbying Congress, the Administration, Centers for Medicare and Medicaid Services (CMS) and health policy experts to remove AP services from the exception. CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
September/October 2013
July / August 2013

STATLINE March 3rd President's Budget
CAP Self-Referral Resource Center
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Original Answer provided July 2013 by the Council on Membership & Professional Development:
The CAP as an organization doesn't prefer any one business model over another. Our mission is to promote the advancement of medicine, the specialty of pathologists and the interests of pathologists and their patients. We

recognize that pathologists practice in many different types of arrangements – in hospitals, in independent laboratories, under employment arrangements, and as independent contractors, among other practice models.

It is not the CAP's role to prefer any one arrangement over another. That said, CAP opposes arrangements that violate canons of professional ethics. Certain self-referral arrangements raise issues that CAP believes warrant legislative, administrative or enforcement action, and in appropriate circumstances CAP has actively advocated for such actions.

Answer provided by Council on Government & Professional Affairs:
The CAP advocates closing the loophole for anatomic pathology in the "in-office ancillary services" exception to the federal Stark physician self-referral prohibition. The CAP believes, supported by mounting evidence, that self-referral arrangements provide an incentive for overutilization of services without greater benefit to the patient. The CAP is actively lobbying Congress, the Administration, Centers for Medicare and Medicaid Services (CMS) and health policy experts to remove anatomic pathology services from the exception. CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information
Please see CGPA's September/October 2012 Report to HOD (i.e. self-referral Federal and state)
CGPA Reports
Please see CGPA's response to HOD Delegate questions in 2012 on self-referral
Self-referral Resource Center

7. Does the CAP intend to revisit the TC grandfather ruling?

Answer provided by Council on Government & Professional Affairs:
No. After more than 10 years of CAP successfully advocating Congress to extend the technical component (TC) grandfather provision (which the CAP fought for year after year), the provision expired at the end of June, 2012. Congress has no plans to revisit the issue.

The CAP supported and had legislation introduced to make the grandfather permanent. Several factors converged to ultimately sunset the provision. Several of our most committed champions in Congress lost their re-election bids. In addition, given the pressures to curb health care costs and scrutinize every Medicare dollar, Congress took its cues from a 2003 GAO report which specifically recommended ending the TC grandfather. Although the CAP believed the study was flawed and successfully rebutted its conclusions for years, the report got a new look in this cost-conscious congressional environment. The report contended that payment for the TC grandfather was already included in the hospital DRG so that Medicare was effectively paying twice under the grandfather policy (payment to the laboratory as well as through the DRG). Moreover, CMS continued to oppose the grandfather provision, contending that its initial purpose was to provide a period of transition, rather than a permanent payment policy. Policy makers felt that rural areas would continue to be protected since they could be reimbursed "reasonable cost" by Medicare for the TC. The "grandfather" provision was one of several health care "extenders" that Congress felt should not continue.

Background Information:
TC Grandfather Resources
Statline Article 6-12-13

Please see CGPA's response to HOD Delegate questions in 2012 on TC Grandfather.

8. Does the CAP have a plan to help us communicate with other CAP members in our state? Will the CAP host state society websites?

Answer provided by Council on Membership & Professional Development:

The CMPD is collaborating with the House of Delegates to support six state pilot communication projects designed to foster open, effective interaction among delegates within each state. The CAP is in the process of redesigning its website for launch in July of 2014. Opportunities to extend interactive web services at the local and state levels will be addressed subsequent to the launch of the CAP website.

9. What is the CAP doing to address impending pathologists' workforce shortages, especially those involving new technologies?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
In December 2013, CAP co-convened the Pathology Workforce Summit, at which representatives of 24 national professional organizations representing pathology and medical education developed a common set of priorities on workforce issues affecting the future of pathology and laboratory medicine. Participants agreed on three key recommendations to address future workforce issues: (1) reassessing what every pathologist needs to know and identifying new ways to ensure that adequate numbers of pathologists acquire both general skills and subspecialized expertise, especially in key emerging areas; (2) organizing pathology to attract and recruit highly qualified medical and STEM (science, technology, engineering, and mathematics) students into pathology and laboratory professions; and, (3) reevaluating long-term training expectations to propagate an outlook of lifelong learning to maintain or enhance career opportunities and applicability to current health care delivery systems and payment models. CAP is working with other specialty organizations to address these issues, most notably in developing a survey of employers and of new-in-practice pathologists to assess how well their training aligns with their professional needs.

Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014

Statline Article Workforce Summit
Statline Article Joint Statement

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Original Answer provided July 2013 by Council on Government & Professional Affairs:

In 2009, the CAP began a study to examine the current and future pathologist workforce. The analysis included entrants and exits from the workforce and expected changes due to the advent of new care delivery models (e.g. coordinated care/ACOs) and new technologies (e.g. in vivo microscopy and genomics). The methodology detailing the pathology workforce supply will be released in a paper published this fall in Archives of Pathology. The methodology for the pathology workforce demand will be published at a later date. Recently, CAP presented the preliminary findings of the CAP workforce study at the Association of American Medical Colleges' Physician Workforce Research Conference and the CAP Policy Meeting. The CAP Policy Roundtable is developing a more comprehensive paper that demonstrates the future shortage in the supply of pathologists and implications of such a shortage and a paper detailing policy recommendations. CAP Advocacy staff and the Policy Roundtable have begun to reach out to key policymakers including legislators to raise awareness of the coming shortage. CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Material from 2013 CAP Policy Meeting

10. Does the CAP have a position on annual PAP smear testing?

April 23, 2014 Update provided by Governor and Chair of Council on Scientific Affairs, Bruce Williams, MD, FCAP:
The Cytopathology Committee will review the policy in April 2014 and make appropriate changes.

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Original Answer provided by Governor and Chair of Council on Scientific Affairs, Bruce Williams, MD, FCAP:
Does the College have an official position on the issue?
Yes, there is a policy entitled Frequency of Cervical Cancer Screening located at:

http://www.cap.org/apps/cap.portal?_nfpb=true&cntvwrPtlt_actionOverride=%2Fportlets%2FcontentViewer%2Fshow&_windowLabel=cntvwrPtlt&cntvwrPtlt%7bactionForm.contentReference%7d=policies%2Fpolicy_appFF.html&_state=maximized&_pageLabel=cntvwr

How is the College handling this issue?
CAP staff and the Cytopathology Committee collaborative work to address any issues that may arise and refine the policy, if necessary.

What is the desired outcome?
The Frequency of Cervical Cancer Screening Policy will provide the most up-to-date, evidence-based position on Pap screening guidelines.

What is the overall strategy by which to achieve this desired outcome?
The policy will be reviewed at regularly at set intervals and also when new, evidence-based data becomes available.

Where are we with this now?
The Cytopathology Committee reviewed this policy in January of 2013 and revisions are forthcoming.

What are the next steps?
The Cytopathology Committee will continue to monitor evidence-based research and other organizations that promulgate Pap screening guidelines.

11. Does the CAP have plans to increase the learning potential of laboratory accreditation inspections?

Answer provided by Council on Education:
CAP offers CME/CE online activities to help inspectors, both team leaders and team members, prepare for their role as an LAP inspector. Recent enhancements to the inspector training online courses includes making them accessible on all devices and including “tip sheets” that can be printed or downloaded to a mobile device for real-time access during the inspection. In addition the inspector training courses can be used by laboratories to help them prepare for their own inspections. The inspector training program is updated annually.

CAP also continues to offer the Continuous Compliance Master Series, a series of webinars/audioconferences to help laboratories maintain continuous compliance with accreditation requirements. The Continuous Compliance Master Series program is offered annually, with new topics presented each year.

Original Answer provided by Governor and Council Chair on Accreditation, Richard Gomez, MD, FCAP:
CAP continuously evaluates opportunities to improve the value of its accreditation programs. Education among peers is a guiding principle of all CAP programs and services. The accreditation program provides education through a number of media ranging from inspections, mandatory inspector training, checklist and proficiency testing tools, to audio-conferences and webinars. Unfortunately, there are some restrictions to CAP applying CME and CE to inspections.
As marketplace trends place increasing pressure on inspectors and inspected laboratories to be more efficient in on-site assessments, we intend to balance their interest in sharing laboratory best practices with regulatory obligations with a viable model. We hope to be able to provide accredited laboratories with a dashboard of quality metrics including how they are performing compared to similar laboratories.

April 22, 2014 Update provided by Governor and Council Chair on Accreditation, Richard Gomez, MD, FCAP.
The project requires close coordination between COA's Accreditation Education Committee, its Inspection Process Committee, the Council on Education (COE), and professional staff that will take many months at minimum prior to formulating a joint recommendation & making a decision. Further, we can't change/implement our process during our upcoming CMS review as accreditation materials are “frozen” during that period. Inspection CME was originally discontinued due to COEs concerns as a result of more strict guidance from our CME accreditation provider. At that time we evaluated several options, none of which met requirements. We may not find a workable solution despite our preference to do so. As stated in our response we are interested in reevaluating alternatives.

12. Why does the CAP accredit laboratories owned by non-pathologists e.g. urologists, gastroenterologists?

Answer provided by Governor and Council Chair on Accreditation, Richard Gomez, MD, FCAP:
The CAP currently provides laboratory accreditation services to any domestic clinical laboratory that meets its eligibility requirements regardless of ownership. Our mission in accreditation is to foster improvements in laboratory care and patient safety while ensuring the ongoing viability of our programs. We realize that in doing so we may find members who disagree with this part of our accreditation business. We know that our accreditation of the in-office laboratories ensures quality in patient care. The excess revenue derived from laboratory improvement programs is returned to member benefits in many forms including advocacy, education, scientific papers, establishing guidelines and publications.

April 22, 2014 update provided by Governor and Council Chair on Accreditation, Richard Gomez, MD, FCAP:
There is no update necessary for this question as the answer was previously provided.

13. What can CAP members, including those practicing in academic practices, do to help advance the CAP mission?

Answer provided by the Council on Membership & Professional Development:

CAP members continue to generously contribute their professional expertise and time to advance the College's mission. In fact more than 40% of CAP members are directly engaged in laboratory inspections, the development of standards and proficiency tests, advocacy at the local, state and national levels, and community and patient advocacy services. CAP members contribute more than 180,000 hours each year to advance the College's mission.

Members can offer to contribute their talents and time throughout the year by logging on to (Expedited URL coming soon.)

14. Do Governors respond to emails sent by individual CAP members?

The following answer has been provided by CAP President, Stanley J. Robboy, MD, FCAP:
Yes, to the extent the inquiry is pertinent to the particular Board member. For clarity and consistency on communications, please also copy president@cap.org

16. What will be the effect of ACOs on pathology practices? What can pathologists do to prepare for ACOs?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
ACOs and other coordinated care programs offer both opportunities and challenges for pathologists. While base compensation under the federal Medicare ACO or Medicare shared savings program remains fee-for-service, it provides an opportunity to receive incentive payments. Other coordinated care programs in the private sector and elsewhere have slightly different models and may, in fact, not still be fee-for-service. Regardless of compensation, coordinated care models will hinge on movement to a team-based model and will require pathologists to focus even more on being part of a care team if they are not already and to make their contributions in this environment known.

Some things pathologists can do to prepare for ACOs if they have not done so already, include: 1) first and foremost, engage with ACO leadership and position themselves to be part of the leadership and governance structure; 2) work with clinicians to develop evidence-based guidelines for optimal use of laboratory tests to improve clinical outcomes by reducing unnecessary testing and the time required to diagnose disease; 3) collaborate with treating physicians on proper test selection, diagnosis, and treatment; and 4) assist with population management as stewards of vast amounts of laboratory and other clinical data.
On the more practical and less clinical front; pathologists will need to be proactive by:

- Reaching out to local ACO organizers and leaders.
- Explaining and promoting how pathology and laboratory medicine contribute to ACO goals.

- Seeking leadership position by joining ACO committees and governance structure.
- Join CAP's ACO Network at aco@cap.org if you are at an institution that is already, or will be, an ACO.
- Document how pathologists have contributed to enhanced outcomes, more appropriate care, and cost reductions for the ACO. The tools that comprise CAP's value based business center launched at CAP '13 can assist with this. These tools can be accessed on the CAP ACO resource center at:

Background:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014
July / August 2013

Value Based Resource Center

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Original Answer provided July 2013 by Council on Government & Professional Affairs:
ACOs and other coordinated care programs offer both opportunities and challenges for pathologists. While base compensation under the federal Medicare ACO or Medicare shared savings program remains fee-for-service, it provides an opportunity to receive incentive payments. Other coordinated care programs in the private sector and elsewhere have slightly different models and may, in fact, not still be fee-for-service. Regardless of compensation, coordinated care models will hinge on movement to a team-based model and will require pathologists to focus even more on being part of a care team if they are not already.

Some things pathologists can do to prepare for ACOs include: 1) first and foremost, engage with ACO leadership and position themselves to be part of the leadership and governance structure; 2) pathologists, working with clinicians, will have greater opportunity and reason to develop evidence-based guidelines for optimal use of laboratory tests to improve clinical outcomes by reducing unnecessary testing and the time required to diagnose disease; 3) collaborate with treating physicians on proper test selection, diagnosis, and treatment; and 4) assist with population management as stewards of vast amounts of laboratory and other clinical data.

On the more practical and less clinical front; pathologists will need to be proactive by:

- Reaching out to local ACO organizers and leaders.
- Explaining and promoting how pathology and laboratory medicine contribute to ACO goals.
- Seeking leadership position by joining ACO committees and governance structure.
- Join CAP's ACO Network at aco@cap.org.
- Document how pathologists have contributed to enhanced outcomes, more appropriate care, and cost reductions for the ACO.

17. Where can members learn what ACO activities are occurring in my state? Does the CAP maintain registries of pathologist participation in ACOs?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
There are several resources HOD delegates can learn more about ACO activities including:

- The Centers to Medicare and Medicaid Services (CMS) website lists participating providers by region in various programs including the Medicare Shared Savings Program, CMMI Advanced Payment ACO and Bundled Payment Care Improvement Initiative, Pioneer ACO Program, and State Innovation Models Initiative. CMS updates these lists as new participants join the programs.
- The CAP ACO network is comprised of members at existing ACOs or organizations in the process of or assessing becoming ACOs. Membership is open to members who fit these criteria. Existing members of the network hale from states throughout the country.
- There are a variety of other publicly available resources, some of them which can be accessed from CAP's ACO resource center on CAP's website CAP's ACO Resource Center (ACO Resource Center). The resource center does include a map of ACOs throughout the country. Others sources are the website of the Commonwealth Fund website http://www.commonwealthfund.org/ a private foundation that focuses on

improved quality, and greater efficiency in the healthcare system, track state efforts in accountable care models.

CGPA is pleased to provide an update to the HOD as this issue continues to develop.
Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014
July / August 2013

CAP's ACO Resource Center

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Original Answer provided July 2013 by Council on Government & Professional Affairs:
There are several resources HOD delegates can learn more about ACO activities including:

- The Centers to Medicare and Medicaid Services (CMS) website lists participating providers by region in various programs including the Medicare Shared Savings Program, CMMI Advanced Payment ACO and Bundled Payment Care Improvement Initiative, Pioneer ACO Program, and State Innovation Models Initiative
- The CAP ACO network is comprised of members at existing ACOs or organizations in the process of or assessing becoming ACOs. Membership is open to members who fit these criteria.

· There are a variety of other publicly available resources, some of them which can be accessed from CAP's ACO resource center on CAP's website CAP's ACO Resource Center Others such as the website of the Commonwealth Fund website http://www.commonwealthfund.org/ a private foundation that focuses on improved quality, and greater efficiency in the healthcare system, track state efforts in accountable care models.

CGPA is pleased to provide an update to the HOD as this issue continues to develop.
Background Information:
Please see CGPA's response to HOD Delegate questions in 2012 on ACOs

CAP's ACO Resource Center
CAP's ACO White Paper
ACO FAQs
2012 ACO Summit

18. Where can members learn about how pathologists can provide value and lower costs in health care? Where can members learn about new payment models?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
Members can access this information at the following:

On the CAP website CAP's ACO Resource Center

- HOD delegates can find CAPs ACO/Coordinated Care online resource center; ACO panel discussion at CAP's 2013 Policy Meeting moderated by a member of the CAP ACO network on which an industry leader from Premier along with a pathologist in an ACO of community hospitals and providers shared his lessons learned.
- The Centers to Medicare and Medicaid Services (CMS) website CMS' ACO Page (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/), CMMI Advanced Payment ACO and Bundled Payment Care Improvement Initiative, Pioneer ACO Program, and State Innovation Models Initiative
- There are a variety of other publicly available resources, some of them which can be accessed from CAP's ACO resource center on CAP's website. Others such as the website of the Commonwealth Fund website, a private foundation that focuses on improved quality and greater efficiency in the healthcare system, track state efforts in accountable care models.

CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
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Medicare Shared Savings Program
CMS Innovation

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Original Answer provided July 2013 by Council on Government & Professional Affairs:
Members can access this information at the following:

- On the CAP website CAP's ACO Resource Center HOD delegates can find CAPs ACO/Coordinated Care online resource center; ACO panel discussion at CAP's 2013 Policy Meeting including an industry leader from Premier along with a pathologists in an ACO of community hospitals and providers sharing his lessons learned; CAP's ACO Network and Promising Practice Pathways; and CAP's Policy Roundtable White paper.
- The Centers to Medicare and Medicaid Services (CMS) website CMS' ACO Page that list participating providers by region in various programs including the Medicare Shared Savings Program, CMMI Advanced Payment ACO and Bundled Payment Care Improvement Initiative, Pioneer ACO Program, and State Innovation Models Initiative

There are a variety of other publicly available resources, some of them which can be accessed from CAP's ACO resource center on CAP's website. Others such as the website of the Commonwealth Fund website, a private foundation that focuses on improved quality and greater efficiency in the healthcare system, track state efforts in accountable care models.

CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Please see CGPA's response to HOD Delegate questions in 2012 on ACOs

CAP's ACO Resource Center
CAP's ACO White Paper
ACO FAQs
2012 ACO Summit

Answer provided by Council on Education:
A number of resources, both CME/SAM and non-credit bearing, can be found in the CAP Learning Portal. A few examples:

- Demonstrating the Value of Pathology Services: an online 1.25 CME/SAM course educating pathologists on promoting the value of their services as a critical part of the patient healthcare team and highlighting strategies and tools for creating and promoting value.
- The ACO Opportunity: an on-demand webinar featuring Drs. Richard C. Friedberg, Donald A. Karcher, and Jonathan L. Myles in a discussion of the pathologists' role in Accountable Care Organizations (ACOs).
- Quality Management Essentials: a 1.5 CME/SAM course focusing on quality requirements as they relate to laboratory operations. Key elements include: 1) using relevant data to assess the value and appropriateness of new tests in terms of their ability to improve patient care and enhance laboratory services, and 2) creating a quality management program that includes use of appropriate monitors and quality improvement tools for tracking performance of both the quality program and individual continuous quality improvement projects.
- A Structured Approach to New Method Implementation: an on-demand webinar focusing on one laboratory`s approach to new method implementation that can be modified to fit the needs of your laboratory.

Check the CAP Learning Portal regularly to find the current offerings; use the Search function on the Learning Options tab.

19. How can we mobilize the CAP members in our state to address issues that may affect us adversely, e.g. direct billing?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
By working with State Pathology Societies, CAP has effectively mobilized large numbers of pathologists in our advocacy efforts at the state level. For the most part, this effort is undertaken using e-mail contacts, telephone contacts, and third party software that facilitate e-mail communications with State elected officials. This year in Illinois, over 200 pathologists participated in grassroots communications on the direct billing legislation pending in that state. The CAP's past success in enacting or defeating state legislation, with formidable opposition, is strong evidence that grassroots efforts at the State level are in fact effective. However, the College believes that the strengthening of State Pathology Societies is critical to further maximizing the grassroots capabilities of the profession. CGPA is pleased to provide an update to the HOD as this issue continues to develop.

Background Information:
Statline: Virginia Lawmakers Unanimously Approve Anti-Markup Bill 2014
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Original Answer provided July 2013 by Council on Government & Professional Affairs:
By working with State Pathology Societies, CAP has effectively mobilized large numbers of pathologists in our advocacy efforts at the state level. For the most part, this effort is undertaken using e-mail contacts, telephone contacts, and third party software that facilitate e-mail communications with State elected officials. This year in Illinois, over 200 pathologists participated in grass roots communications on the direct billing legislation pending in that state. The CAP's past success in enacting or defeating state legislation, with formidable opposition, is strong evidence that grass roots efforts at the State level are in fact effective. However, the College believes that the strengthening of State Pathology Societies is critical to further maximizing the grass roots capabilities of the profession. CGPA is pleased to provide an update to the HOD as this issue continues to develop.
Background Information:
Please see CGPA's March and April 2013 Report to HOD Members; (i.e Direct Billing Law Clarified in Indiana) CGPA Reports
Please see CGPA's response to HOD Delegate questions in 2012 on Direct Billing

Direct Billing Issue Brief

20. Where can members find advice or guidance on CPT coding e.g. nuances of IHC coding?

May 28, 2014 UPDATE Provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
Pathologists are facing new challenges billing immunohistochemistry (IHC) services for both government and commercial payers for 2014. To promote further understanding of new policies under the American Medical Association (AMA) Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services (CMS), the CAP continues to provide education on these changes to its members.

Background Information:
IHC Billing Education
CAP Clarifies IHC Billing Policies
The CGPA will continue to update the HOD when further information is available
++
July 2013 Original Answer provided by Council on Government & Professional Affairs:
The CMS' 2012/2013 NCCI Policy Manual includes an issue of significant concern regarding Immunohistochemistry. The College continues to pursue resolution of this issue as a matter of policy concern, including communication with the agency and CPT. The CGPA will update the HOD when further information is available.
CAP is strongly committed to its role as the leader in pathology CPT coding advocacy. However, due to legal limitations CAP is not able to respond to individual CPT questions. In response to this limitation, CAP has arranged for members to receive a discount on subscriptions to a CPT coding service. Through the PathLab Coding Solutions service, subscribers receive timely written responses supported by authoritative documentation to their CPT questions. Others may subscribe to the service but they will not receive the CAP member discount. A subscription is

required to submit a question to PathLab Coding Solutions. More information on subscribing to PathLab Coding Solutions is available online from CAP's CPT Coding Resource center page (accessed from the Reference Resources and Publications tab at www.cap.org) or by contacting Leigh Polk or Diana Brooks of PSA at 843-629-2941.
Background Information:

CAP's CPT Coding Resource Center

21. Where can I learn about PQRS payments?

May 28, 2014 UPDATE** provided by Governor and Chair of Council on Government & Professional Affairs, George F. Kwass, MD, FCAP:
For information about the program and the pathology measures in the PQRS program, please see the CAP PQRS Resource Center. CGPA is pleased to provide an update to the HOD as this issue continues to develop. CAP held a Webinar on the PQRS on March 31, 2014 (archived webinar is available at the PQRS Resource Center). CAP does not have access to specific information about CMS PQRS payments. Please contact the CMS Quality Net Helps Desk for payment questions.

QualityNet Help Desk: - Monday – Friday: 8:00 am – 8:00 pm EST –
Phone: (866) 288-8912 (TTY 1-877-715-6222) –
Fax: (888) 329-7377 –
Email: qnetsupport@sdps.org

Background Information:
Please see the following CGPA reports to the HOD for addition background information at the following link: HOD Reports and Agenda
January/February 2014
November / December

PQRS Resource Center
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Original Answer provided by Council on Government & Professional Affairs July 2013:
For information about the program and the pathology measures in the PQRS program, please see the CAP PQRS Resource Center. CGPA is pleased to provide an update to the HOD as this issue continues to develop. CAP does not have access to specific information about CMS PQRS payments. Please contact the CMS Quality Net Helps Desk for payment questions.

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Phone: (866) 288-8912 (TTY 1-877-715-6222) –
Fax: (888) 329-7377 –
Email: qnetsupport@sdps.org
Background Information:
CGPA Reports
Please see CGPA's March and April 2013 Report to HOD Members
Please see CGPA's September/October 2012 Report to HOD; (i.e. Quality Reporting Initiatives)

22. What will be the effect of the TC grandfather decision on self-referral?

Answer provided by Council on Government & Professional Affairs:
There is no direct impact. Although some "in-office" pathology laboratories perform the technical component of anatomic pathology, billing under the "grandfather" provision was limited to certain independent laboratories. Ending the "grandfather" policy will not prevent "in-office" laboratories from performing and billing for the TC of anatomic pathology services. "In-office" laboratories that perform and bill Medicare for either the TC or PC of anatomic pathology or both do so under the "in-office ancillary services" exception of the Stark physician self-referral law.

23. Where can I learn about online AP Reporting? Developing my own template reports?

Answer provided by Council on Scientific Affairs:
The CAP currently does not have an official position on the development of general online AP reporting templates.

Please refer to the two publications found in the Archives of Pathology and Laboratory Medicine that recommend which elements to include in the Surgical Pathology Report and provide guidance on how to format these reports.

Goldsmith JD, Siegal GP, Suster S, Wheeler TM, Brown RW. Reporting Guidelines for Clinical Laboratory Reports in Surgical Pathology*. Arch Pathol Lab Med.* 2008;132:1608-1616.

Valenstein P, Formatting Pathology Reports. *Arch Pathol Lab Med.* 2008;132:84-94.

The CAP does offer electronic Cancer Checklists (eCC) which generate synoptic reports using the data elements found in the CAP Cancer Protocols. The eCC advance the management and interoperability of health information through its extensible Markup Language (XML) format that can be integrated easily into existing pathology and cancer registry systems. More information on eCC licensing can be found at www.sts.cap.org.

24. How will the CAP collate and share Peer2Peer data?

Answer provided by Council on Membership & Professional Development:

peer2peer data
The House of Delegates requested information on the collation and sharing of peer2peer (p2p) data. Following are a list of current and future practices:

- A master Knowledge Management Solution (KMS) database houses all issues and solutions identified through completed p2p events. The KMS is continuously updated.
- CAP Partners (CAP staff members assigned to support individual p2p events) complete a conversation report post-p2p event documenting needs and action items based on the host practice's discussion.
    - The completed report is sent to the p2p Program Coordinator and added to the KMS.
    - The CAP Partner (CP) follows through on action items and documents continued ongoing interaction with the practice in the CAP Partner Log.
    - CPs are asked to update the CP Log on a monthly basis.
    - CP Logs are reviewed regularly by the p2p Program Coordinator.

- The Vice President from each division of the College has designated a p2p division contact:
    - The p2p division contact receives completed conversation reports post-p2p events.
    - The p2p division contact reviews the reports, identifies any issues or gaps that can be addressed by that division, and contacts the appropriate responders.
    - Responses/actions are reported to the p2p Program Coordinator and documented in the KMS.
    - The p2p Program Coordinator shares the response/action with the CAP Partner who delivers the information and any resources to the Head of Group of the p2p.
- The p2p Program Coordinator shares regular KMS updates with the Practice Management Committee for the identification and creation of necessary resources.
- CPs receive monthly bulletins identifying the latest resources available for practices. CPs are encouraged to distribute the information to their host practices, especially those resources appropriate to the specific issues raised at the practice's p2p event.
- The p2p Program is in the process of developing a p2p webpage devoted to common issues and solutions available on cap.org for members only.

25. What can members do to convince clinicians to consider submitting FNA samples rather than core biopsies?

Answer provided by Council on Scientific Affairs:
Does the College have an official position on the issue?
The College does not have an official position on fine needle aspiration submission as opposed to core biopsies at this time. However, the CAP Cytopathology Committee believes that pathologists need to educate clinicians about the benefits of FNA and assist them in choosing the most appropriate biopsy method for the patient and the potential lesion. In some instances, FNA is the preferred method of sample procurement (e.g., thyroid and lymph node), whereas in other cases, the best method may be dependent on the differential diagnosis and anticipated ancillary tests required for definitive interpretation.

What are the next steps?
The College suggests that pathologists be actively involved in consensus conferences that address issues where the utility of FNA is optimal. Additionally, since there is peer-reviewed literature discussing the benefits of FNA over core biopsies in specific situations, the College suggests that interested parties should submit an idea proposal to the Center to determine if there is enough data to develop guidelines on the preferred procurement method for specific samples. This idea submission form can be found at:

http://www.cap.org/apps/docs/membership/transformation/new/Center_Idea_Submission_Form.pdf

26. How can members involve themselves in decisions about electronic medical records at both the state and hospital levels?

Answer provided by Council on Education and Diagnostic Intelligence and Health Information Technology (DIHIT) Committee:

Electronic health records (EHRs) are transforming the practice of medicine and have profound implications for pathologists and their laboratories. Because EHRs vary in how and how well they handle laboratory information, there are new risks of problems in laboratory information handling that can lead to adverse effects on patients and laboratory operations. There are also opportunities for new professional roles for pathologists. While there is no "official" position for CAP to take on this issue, CAP supports the idea that pathologists have important roles to play in advocating for effective and appropriate management of laboratory information in the EHR.

CAP has been very active in this area. The CAP Advocacy office in Washington DC, working with a joint CGPA-DIHIT task force, has spent considerable time and energy arguing for pathologists' concerns in the EHR "meaningful use" regulations. Efforts have also included submitting lengthy and detailed responses and recommendations to the Office of the National Coordinator for HIT and to CMS regarding concerns over the handling of laboratory information in EHRs and also delineating the need for pathologists' expertise in EHR efforts. Separately, another informatics workgroup in CAP Education is in the process of developing informatics competency models and eventually curriculum outlines to inform CAP educational efforts in this area.

A workgroup of the CAP's DIHIT committee is creating a 4-part series of papers on the topic of empowering the pathologist in the EHR era. This series aims to provide background information and guidance to pathologists, and their laboratories, on how to best adapt to and succeed in the environment of expanding EHR use. The workgroup plans, within the next two months, to submit these to Archives of Pathology and Laboratory Medicine for peer review and publication. Some of the content and issues cover are briefly highlighted below.

A early step for pathologists is to improve their awareness of the importance and ramifications of EHRs for pathology, including: 1) specific regulatory requirement requirements, 2) issues in exchanging laboratory orders and results with EHRs, 3) control over laboratory information system selection, and 4) probably most importantly, the ways in which clinicians interact with laboratory information in the EHR (e.g. ordering tests, viewing results).

Probably the most important thing that members can do to involve themselves in EHR decisions is to recognize - and to accept - that laboratory information management issues in the EHR are now part of laboratory operations and patient care and should be treated as such. This mindset can spur pathologists to take the necessary steps to reach

out beyond the laboratory in order to influence EHR decisions. EHR issues do not stop at the selection phase, and ongoing engagement of pathologists and laboratories in the implementation phase is important to success.

A suggested objective for pathologists in this regard is to increase their visibility, credibility, and influence in the institution on issues related to EHRs. Tactics pathologists might consider include:

- Participate in EHR selection and implementation processes - participate in selection committees, attend demonstration, contribute expertise to functional requirements/RFPs
- Get involved in formal EHR-related processes and groups in the institution on an ongoing basis
- Build key relationships with those responsible for EHR matters in the institution
- Document and communicate laboratory's contributions to EHR efforts and troubleshooting
- Cultivate EHR-laboratory expertise among laboratory staff so that they can represent the laboratory and contribute to EHR operational process decisions
- Learn about the institution's involvement, if any, in state health information exchanges (HIEs) and whether the local HIE affects the laboratory.

27. What is the CAP doing to make CAP courses Mac-compatible?

Answer provided by Council on Education:
The College has been making plans to remedy the Mac incompatibility with learning activities. The primary obstacle for Mac and tablet access today is that the current Learning Management System (LMS) is only compatible with the Windows operating system and Internet Explorer browser. In May of 2013, CAP Learning received approval to replace the current LMS software so that it will work with any operating system and browser as well as tablet and mobile devices. A project team consisting of CAP Learning, IS and Finance staff and two members has narrowed down a list of potential vendors and is now in the final stage of vendor selection. Once the vendor is selected, formal project planning will take place. Our intent is to begin work in the fourth quarter of 2013 and to have the new LMS in place by end of third quarter 2014.

In the meantime, CAP Learning recreated the two highest volume courses, those for Inspection Training, and is hosting them outside the current LMS so that they are accessible via any device; thereby, overcoming the barriers to access for these required courses.

ICD-10 Information

This topic was identified at the Fall ’14 House of Delegates meeting as being important to delegates in their practices. This section contains information available on cap.org on this topic.

Prepare Now for ICD-10 Transition

What Do Pathology Practices Need to Know Now?

The ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 and ICD-10CM code sets. Effective 10/1/2014, ICD-10 diagnosis codes must be used for all health care services provided in the U.S. ICD-10CM procedure codes must be used for all hospital inpatient procedures. Claims with ICD-9 codes for services provided on or after 10/1/2014 will not be processed nor paid. The purpose of this document is to provide pathology practices with important steps to consider while preparing for the transition to ICD-10. As of January 1, 2012, practices should have already met the HIPAA transaction deadline for implementing version 5010 **(cms.gov/ElectronicBillingEdit Trans/18_5010D0.asp)**.

Steps to help Pathology Practices get started:

- Establish a plan to address the impact of new ICD-10 coding.
- Consult with your billing service or medical billing software vendor about their compliance plans. Questions to ask:
    - Will their software be able to submit both ICD9 and ICD-10 codes as of 10/1/2014? (Services with dates of service prior to 10/1/2014 will need to be coded using ICD-9)
    - Will there be a cost involved for the software update?
- Consult with your major payors on their compliance plans for ICD-10
- Practices that provide billing and software development internally should plan for medical records/coding, clinical, IT, and finance staff to coordinate on ICD-10 transition efforts.
- Your systems should be prepared to handle a mix of ICD-9 and ICD-10 coding, as not all ordering and claim processing systems will be ready for the date of service and inpatient date of discharge by the October 1, 2014, ICD-10 implementation date.
- Learn what changes will occur for ordering and diagnosis of ICD coding for cases from your key and influential physicians.

- Look at the current coding and use the resources listed below to see how these cases will be coded under ICD-10.

- In particular, notice how the new coding system can be used to better measure outcomes, a key concept in coordinate care.

- Based on what you discover, determine if the ordering physician will need more or different information or if you must adapt the contents of your pathology report to support the new coding system.

- Estimate and **secure budget** (potential costs include updates to practice management systems, new coding guides and superbills, staff training)

The changes you discover may be subtle, but they can be turned into a competitive advantage, having a positive effect on your hospital's and referring physicians' ability to adapt to ICD-10 requirements. Conversely, if you do not make the changes, your practice may find itself at a competitive disadvantage. CMS and other provide several resources to assist with this transition.

For additional resources visit the Web based entry point for CMS's resources at **cms.gov/ICD10**, where you can find more detailed information on transitioning from ICD-9 to ICD-10 (E.G., General Equivalence Mappings [GEM], Reimbursement mappings) is available at **2011 ICD-10-CM and GEMs** link on the **cms.gov/ICD10** Web page. You may also visit the Coding and Payment section of **cap.org/practicemanagement**.

Coding and Payment

International Classification of Diseases (ICD)

ICD-Ninth Revision (ICD-9)

- **ICD9DATA.COM**
  Online catalog of ICD-9, Clinical Modification codes

ICD-Tenth Revision (ICD-10)

- **ONLINE CATALOG OF ICD-10 CLINICAL MODIFICATION CODES**
- ICD-10 - CMS General Resources
  Information and resources regarding the transition to ICD-10.
  - **CHECKLISTS AND TIMELINES AT A GLANCE**
  - **DATES OF SERVICE: IS IT ICD-9 OR ICD-10?**
  - **ICD-10 FINAL RULE**
  - **ICD-10 TRANSITION: AN INTRODUCTION** (PDF, 324 KB)
  - **ICD-10 BASICS FOR MEDICAL PRACTICES** (PDF, 312 KB)
  - **ICD-10 LARGE PROVIDERS IMPLEMENTATION TIMELINE** (PDF, 689 KB)
  - **ICD-10 SMALL PROVIDERS IMPLEMENTATION TIMELINE** (PDF, 724 KB)
  - **PREPARE NOW FOR ICD-10 TRANSITION** (PDF, 78 KB)
  - **ICD-10 - LINK TO AHIMA**

http://www.ahima.org/icd10/

CHOOSE YOUR PATH TO ICD-10

CMS AND AHIMA: ICD-10 CLINICAL DOCUMENTATION IMPROVEMENT WEBINAR

Free Event Recording

Register to view recording

View Slides

ICD-10 FAQS

Read answers for top ICD-10 questions.

View FAQs

ICD-10-CM/PCS DOCUMENTATION TIPS

This large library of CDI ICD-10 documentation tips focuses on the language and/or wording that will garnish greater details and specificity of the coded data for a given diagnosis, condition, disease and/or surgical procedure.

View Documentation Tips

ALL ICD10

QUICK LINKS

Helpful ICD-10 Resources

Achieving ICD-10-CM/PCS Compliance in 2015: Staying the Course for Better Healthcare

ICD-10 Implementation Toolkit

ICD-10 Preparation Checklist

CMS Road To 10 Resources

MLN Connects ICD-10 Coding Basics Video

Historical ICD Timeline

ICD-10 Playbook

Top Ten ICD-10-CM/PCS Questions

Upcoming Events

02/24: CDI & ICD-10 Documentation Tips

02/25: Results and Implications of the First Survey of Information Governance Practices in Healthcare

03/03: The Top 20 ICD-10 Documentation Issues that Cause DRG Changes

03/16: CDIP Exam Prep Workshop

03/19: Using CDI Programs to Improve Quality Reporting

03/23: Leadership & Advocacy and Hill Day

View all Events

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

ICD-10

Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

The ICD-10 Transition: An Introduction

The ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. This fact sheet provides background on the ICD-10 transition, general guidance on how to prepare for it, and resources for more information.

About ICD-10

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding

2. ICD-10-PCS for inpatient procedure coding

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

Who Needs to Transition

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT coding for outpatient procedures.

ICD-10 Resources

NEW ICD-10 DEADLINE
OCT 1, 2014

There are many professional, clinical, and trade associations offering ICD-10 information, educational resources, and checklists. Call or check the websites of your associations and other industry groups to see what resources are available.

The CMS website has official resources to help you prepare for ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition.

Sign up for ICD-10 Email Updates and follow @CMSgov on Twitter for the latest news and resources.

Visit **www.cms.gov/ICD10** for ICD-10 and Version 5010 resources from CMS.

```
I062 Rheumatic aortic stenosis with insufficiency
I068 Other rheumatic aortic valve diseases
I069 Rheumatic aortic valve disease, unspecified
I070 Rheumatic tricuspid stenosis
I071 Rheumatic tricuspid insufficiency
I072   Rheumatic tricuspid stenosis and insufficiency
I078   Other rheumatic tricuspid valve dis
```

Health care providers, payers, clearinghouses, and billing services must be prepared to comply with the transition to ICD-10, which means:

- All electronic transactions must use Version 5010 standards, which have been required since January 1, 2012. Unlike the older Version 4010/4010A standards, Version 5010 accommodates ICD-10 codes.
- ICD-10 diagnosis codes must be used for all health care services provided in the U.S., and ICD-10 procedure codes must be used for all hospital inpatient procedures. Claims with ICD-9 codes for services provided on or after the compliance deadline cannot be paid.

Transitioning to ICD-10

It is important to prepare now for the ICD-10 transition. The following are steps you can take to get started:

- **Providers** – Develop an implementation strategy that includes an assessment of the impact on your organization, a detailed timeline, and budget. Check with your billing service, clearinghouse, or practice management software vendor about their compliance plans. Providers who handle billing and software development internally should plan for medical records/coding, clinical, IT, and finance staff to coordinate on ICD-10 transition efforts.
- **Payers** – Review payment policies since the transition to ICD-10 will involve new coding rules. Ask your software vendors about their readiness plans and timelines for product development, testing, availability, and training for ICD-10. You should have an implementation plan and transition budget in place.
- **Software vendors, clearinghouses, and third-party billing services** – Work with customers to install and test ICD-10 ready products. Take a proactive role in assisting with the transition so your customers can get their claims paid. Products and services will be obsolete if steps are not taken to prepare.

This fact sheet was prepared as a service to the health care industry and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

ICD-10

Official CMS Industry Resources for the ICD-10 Transition

www.cms.gov/ICD10

Large Providers

Implementation Timeline

Please note the dates in this timeline are based on an October 1, 2013, deadline, which HHS has extended to October 1, 2014.

The following is a timeline of essential activities needed to successfully transition to ICD-10. While each organization's implementation may be unique, the following activities and procedures are intended to provide guidance for a smooth transition. Depending on your organization, many of these timelines can be compressed and/or performed at the same time as other tasks. The estimated total duration for each activity is provided.

Actions to Take Immediately

- ❒ Inform core group and senior management of upcoming changes (1 month)
- ❒ Create a governance structure, such as a project management team, interdisciplinary steering committee, executive sponsor and/or ICD-10 coordination manager (1 month)
- ❒ Perform an impact assessment and identify potential changes to existing work flow and business processes (6 months)
  - ❒ Collect information from each department on current use of ICD-9 and the number of staff members who need ICD-10 resources and training. Staff training will most likely involve billing and other financial personnel, coding staff, clinicians, management, and IT staff
  - ❒ Evaluate the effect of ICD-10 on other planned or on-going projects (e.g., Version 5010 transition, EHR adoption and Meaningful Use)
- ❒ Determine business and technical implementation strategy (1 month)
- ❒ Develop and complete implementation plan, including a communications plan (3 months)
- ❒ Estimate and secure budget including costs associated with implementation such as software and software license costs, hardware procurement, and staff training costs (2 months)
- ❒ Contact systems vendors, clearinghouses, and/or billing services to assess their readiness for ICD-10 and evaluate current contracts (2 months)
  - ❒ Determine if systems vendors and/or clearinghouses/billing services will support changes to systems, a timeline and costs for implementation changes, and identify when testing will occur
  - ❒ Determine anticipated testing time and schedule (when they will start, how long they will need, and what will be needed for testing)

- ❒ If vendor(s) provide solution, then engage immediately
- ❒ Begin internal system design and development, if not started already
- ❒ Educate staff on changes in documentation requirements from health plans

Spring 2011

- ❒ Continue and complete an impact assessment and identify potential changes to existing work flow and business processes
  - ❒ Collect information from each department on current use of ICD-9 and the number of staff members who need ICD-10 resources and training. Staff training will most likely involve billing and other financial personnel, coding staff, clinicians, management and IT staff
  - ❒ Evaluate the effect of ICD-10 on other planned or on-going projects (e.g., Version 5010, EHR adoption and Meaningful Use)
- ❒ Continue to develop and complete implementation plan, including a communication plan
- ❒ Continue and complete estimate and secure budget
  - ❒ Include costs associated with implementation such as software and software license costs, hardware procurement, and staff training costs
- ❒ Continue and complete contact with system vendors, clearinghouses, and/or billing services to assess their readiness for ICD-10 and evaluate current contracts
  - ❒ Determine if systems vendors and/or clearinghouses/billing services will support changes to systems, a timeline and costs for implementation changes, and identify when testing will occur
  - ❒ Determine anticipated testing time and schedule (when they will start, how long they will need, and what will be needed for testing)
  - ❒ If vendor provided solution, then engage immediately
- ❒ Continue internal system design and development

Summer 2011

- ❒ Conduct training including educating staff on changes in documentation requirements from health plans
- ❒ Continue internal system design and development (work with vendor providing solution as appropriate)

Fall 2011

- ❒ Continue educating staff on changes in documentation requirements from health plans
- ❒ Continue internal system design and development (work with vendor providing solution as appropriate)

Winter 2012

- Complete system design and development
- Continue to educate staff on changes in documentation requirements from health plans
- Start to conduct internal testing. This must be a coordinated effort with internal coding, billing and technical resources and vendor resources (9 months)
- Data managers should start to collaborate with IT to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy (11 months)

Spring 2012

- Continue to educate staff on changes in documentation requirements from health plans
- Data managers should collaborate with IT to continue implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Summer 2012

- Continue internal testing and vendor code deployment (3 months)
- Data managers should collaborate with IT to continue implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Fall 2012

- Complete educating staff on changes in documentation requirements from health plans
- Begin external testing (10 months)
- Data managers should collaborate with IT to continue implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Winter 2013

- Continue external testing
- Data managers should collaborate with IT to continue implementing the ICD-10 project plan until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Spring 2013

- ❒ Continue external testing
- ❒ Conduct intensive training for coders on day-to-day basis (6 months)
- ❒ Data managers should collaborate with IT to begin implementing the ICD-10 project plan until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Summer 2013

- ❒ Complete external testing
- ❒ Transition ICD-10 systems to production
- ❒ Continue intensive training for coders on day-to-day basis
- ❒ Data managers should collaborate with IT to begin implementing the ICD-10 project plan until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Fall 2013

- ❒ Complete transition of ICD-10 systems to production
- ❒ Complete intensive training for coders on day-to-day basis
- ❒ October 1, 2013: ICD-10 system implementation for full compliance. ICD-9 codes will continue to be used for services provided before October 1, 2013

On-going education and implementation assistance for ICD-10 is available from many professional organizations and associations. Visit the CMS website at www.cms.gov/ICD10 for the latest information and tools to help you prepare for the ICD-10 transition.

CMS consulted resources from the American Medical Association (AMA), the American Health Information Management Association (AHIMA), the North Carolina Healthcare Information & Communications Alliance (NCHICA) and the Workgroup for Electronic Data Interchange (WEDI) in developing this timeline.

CMS CENTERS for MEDICARE & MEDICAID SERVICES ICD-10

Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

ICD-10 Basics for Medical Practices

Begin preparing now for the ICD-10 transition to make sure you are ready by the **October 1, 2013**, compliance deadline. The following quick checklist will assist you with preliminary planning steps.

- ❒ **Identify your current systems and work processes that use ICD-9 codes.** This could include your clinical documentation, encounter forms/superbills, practice management system, electronic health record system, contracts, and public health and quality reporting protocols. It is likely that wherever ICD-9 codes now appear, ICD-10 codes will take their place.
- ❒ **Talk with your practice management system vendor about accommodations for both Version 5010 and ICD-10 codes.** Contact your vendor and ask what updates they are planning to your practice management system for both Version 5010 and ICD-10, and when they expect to have it ready to install. Check your contract to see if upgrades are included as part of your agreement. If you are in the process of making a practice management or related system purchase, ask if it is Version 5010 and ICD-10 ready.
- ❒ **Discuss implementation plans with all your clearinghouses, billing services, and payers to ensure a smooth transition.** Be proactive, don't wait. Contact organizations you conduct business with such as your payers, clearinghouse, or billing service. Ask about their plans for the Version 5010 and ICD-10 compliance and when they will be ready to test their systems for both transitions.
- ❒ **Talk with your payers about how ICD-10 implementation might affect your contracts.** Because ICD-10 codes are much more specific than ICD-9 codes, payers may modify terms of contracts, payment schedules, or reimbursement.
- ❒ **Identify potential changes to work flow and business processes.** Consider changes to existing processes including clinical documentation, encounter forms, and quality and public health reporting.
- ❒ **Assess staff training needs.** Identify the staff in your office who code, or have a need to know the new codes. There are a wide variety of training opportunities and materials available through professional associations, online courses, webinars, and onsite training. If you have a small practice, think about teaming up with other local providers. You might be able, for example, to provide

Background

The ICD-10 transition is coming on **October 1, 2013**. A related change, the transition to Version 5010 standards for electronic transactions happens before then, on **January 1, 2012.** Everyone covered by HIPAA is affected. Now is the time to prepare.

About ICD-10

ICD-10 CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/ Procedure Coding System) consists of two parts:

1. **ICD-10-CM** for diagnosis coding

2. **ICD-10-PCS** for inpatient procedure coding

ICD-10-CM was developed by the Centers for Disease Control and Prevention for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS was developed by the Centers for Medicare & Medicaid Services (CMS) for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

The transition to ICD-10-CM/PCS does **not** affect Current Procedural Terminology (CPT) codes, which will continue to be used for outpatient services.

Visit ***www.cms.gov/ICD10*** for ICD-10 and Version 5010 resources from CMS.

I062 Rheumatic aortic stenosis with insufficiency
I068 Other rheumatic aortic valve diseases
I069 Rheumatic aortic valve disease, unspecified
I070 Rheumatic tricuspid stenosis
I071 Rheumatic tricuspid insufficiency
I072 Rheumatic tricuspid stenosis and insufficiency

training for a staff person from one practice, who can in turn train staff members in other practices. Coding professionals recommend that training take place approximately 6 months prior to the October 1, 2013, compliance date.

- **Budget for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials, and training.** Assess the costs of any necessary software updates, reprinting of superbills, training and related expenses.

- **Conduct test transactions using Version 5010/ICD-10 codes with your payers and clearinghouses.** Testing is critical. Allow yourself enough time to first test that your Version 5010 transactions, and subsequently, claims containing ICD-10 codes are being successfully transmitted and received by your payers and billing service or clearinghouse. Check to see when they will begin testing, and the test days they have scheduled. If you submit electronic claims, you need to have completed internal testing of Version 5010 systems in time to begin external testing with your payers, clearinghouses, billing services, and other business partners by **January 1, 2011**.

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ICD-10

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Small Providers

Implementation Timeline

Please note the dates in this timeline are based on an October 1, 2013, deadline, which HHS has extended to October 1, 2014.

The following is a timeline of essential activities needed to successfully transition to ICD-10. While each organization's implementation may be unique, the following activities and procedures are intended to provide guidance for a smooth transition. Depending on your organization, many of these timelines can be compressed and/or performed at the same time as other tasks. The estimated total duration for each activity is provided.

Actions to Take Immediately

- ❒ Inform physicians and staff of upcoming changes and the practice's implementation plans (1 month)
- ❒ Identify and establish an ICD-10 coordination manager for your practice (1 month)
- ❒ Perform an impact assessment and identify potential changes to existing work flow and business processes (6 months)
  - ❒ Collect information on current use of ICD-9 and a list of staff members who need ICD-10 resources and training. Staff training will most likely involve billing and other financial personnel, coding staff, clinicians, management, and IT staff if applicable
  - ❒ Evaluate the effect of ICD-10 on other planned or on-going projects (e.g., Version 5010 transition, EHR adoption and Meaningful Use)
- ❒ Determine business and technical implementation strategy (1 month)
- ❒ Develop an implementation plan, including a memo/letter communicating the new system changes to staff (3 months)
- ❒ Estimate and secure budget, including all costs associated with implementation such as software and software license costs, hardware procurement, and staff training costs (2 months)
- ❒ Contact systems vendors, clearinghouses, and/or billing services to assess their readiness for ICD-10 and evaluate current contracts (2 months)
  - ❒ Determine if systems vendors and/or clearinghouses/billing services will support changes to systems, supply a timeline and estimate costs for implementation changes, and identify when testing will occur
  - ❒ Determine anticipated testing time and schedule (when they will start, how long they will need, and what will be needed for testing)
  - ❒ If vendor(s) provide solution, then engage immediately
- ❒ Begin internal system design and development, if not started already (work with vendors as needed)

- ❒ Seek resources from CMS, professional and membership organizations to help with transition
- ❒ Educate staff on changes in document requirements from health plans

Spring 2011

- ❒ Continue and complete an impact assessment and identify potential changes to existing work flow and business processes
  - ❒ If applicable, collect information on current use of ICD-9 and the resources needed to transfer to ICD-10
  - ❒ Evaluate the effect of ICD-10 on other planned or ongoing projects (e.g., Version 5010, EHR adoption and Meaningful Use)
- ❒ Continue to develop and complete an implementation plan
- ❒ Continue and complete estimate and secure budget
  - ❒ Include costs associated with implementation such as software and software license costs, hardware procurement, and staff training costs
- ❒ If applicable, continue and complete contact with systems vendors, clearinghouses, and/or billing services to assess their deadlines for ICD-10 and evaluate current contracts
  - ❒ Determine if systems vendors and/or clearing houses billing services will support changes to systems, a timeline and costs for implementation changes, and identify when testing will occur
  - ❒ Determine anticipated testing time and schedule (when they will start, how long they will need, and what will be needed for testing)
  - ❒ If vendor provided solution, then engage immediately
- ❒ Continue internal system design and development (work with vendor providing solution as appropriate)
- ❒ Seek resources from CMS, professional and membership organizations to help with transition

Summer 2011

- ❒ Educate staff on changes in documentation requirements from health plans
- ❒ Continue internal system design and development (work with vendor providing solution as appropriate)
- ❒ Seek resources from CMS, professional and membership organizations to help with transition

Fall 2011

- ❒ Continue educating staff on changes in documentation requirements from health plans
- ❒ Continue internal system design and development (work with vendor providing solution as appropriate)

Winter 2012

- ❒ Complete system design and development
- ❒ Continue to educate staff on changes in documentation requirements from health plans
- ❒ Start to conduct internal testing. This must be a coordinated effort with internal coding, billing and technical resources and/or vendor resources (9 months)
- ❒ Provider or key office personnel should contact IT support personnel to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy (11 months)

Spring 2012

- ❒ Continue to educate staff on changes in documentation requirements from health plans
- ❒ Provider or key office personnel should contact IT support personnel to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Summer 2012

- ❒ Continue to educate staff on changes in documentation requirements from health plans
- ❒ Continue internal testing and vendor code deployment (3 months)
- ❒ Provider or key office personnel should contact IT support personnel to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Fall 2012

- ❒ Complete educating staff on changes in documentation requirements from health plans
- ❒ Complete internal testing and vendor code deployment
- ❒ Begin external testing (10 months)
- ❒ Provider or key office personnel should contact IT support personnel to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Winter 2013

- ❒ Continue external testing
- ❒ Provider or key office personnel should contact IT support personnel to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Spring 2013

- ❒ Continue external testing

- ❒ Conduct intensive training for coders on day-to-day basis (6 months)
- ❒ Provider or key office personnel should contact IT support personnel to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Summer 2013

- ❒ Complete external testing
- ❒ Work with vendor contractor(s) to transition ICD-10 systems to production
- ❒ Continue intensive training for coders on day-to-day basis, if applicable
- ❒ Provider or key office personnel should contact IT support personnel to begin implementing the ICD-10 project plan throughout 2012 until ICD-10 implementation. Action steps include reviewing the sample data reports, testing, and evaluating data for accuracy

Fall 2013

- ❒ Work with vendor contractor(s) to complete transition of ICD-10 systems to production
- ❒ Complete intensive training for coders on day-to-day basis, if applicable
- ❒ October 1, 2013: ICD-10 system implementation for full compliance. ICD-9 codes will continue to be used for services provided before October 1, 2013

On-going education and implementation assistance for ICD-10 is available from many professional organizations and associations. Visit the CMS website at www.cms.gov/ICD10 for the latest information and tools to help you prepare for the ICD-10 transition.

CMS consulted resources from the American Medical Association (AMA), the American Health Information Management Association (AHIMA), the North Carolina Healthcare Information & Communications Alliance (NCHICA) and the Workgroup for Electronic Data Interchange (WEDI) in developing this timeline.

State Pathology Societies

This topic has been identified as important to delegates. This section includes current information on CAP's relationships with state pathology societies.

State Pathology Society Advisory Group (SPS-AG)

At the November 2014 meeting of the Council on Membership and Professional Development (CMPD), Dr. Jhaveri, CMPD Chair, announced a new initiative. A cross-council advisory group composed of members from CMPD and Government and Professional Affairs (CGPA) will develop recommendations on how CAP should interact with State Pathology Societies (SPS) as strategic alliance partners. This initiative will build on prior work done by Membership, Advocacy, and the House of Delegates over the past few years, identifying all of the ways CAP is currently involved with SPS. It will also focus on the value to the CAP and to CAP members in developing SPS relationships and identifying opportunities for collaboration.

SPC-AG will be chaired by:

- Dr. Tim Allen from Texas, CAP Governor and Vice-Chair of CMPD,

Additional members of CMPD serving on this AG are:

- Dr.Gerald Hanson from California, CAP Governor
- Dr. Steve Ruby from Illinois, Chair Practice Mgmt Cmte
- Dr. James Richard, from Michigan, Speaker HOD

The members participating from CGPA are:

- Dr. Joe Saad from Texas, Chair of Federal and State Advisory Committee (FSAC).
- Dr. David Gang from MA, Vice Chair FSAC.

All of these members are leaders in their state pathology societies.
Members will be expected to report back to their respective Councils for input and agreement as this process moves forward. Final recommendations will go to the Board for approval.

This advisory group will be supported by senior staff from Membership and Advocacy including:

- Maryrose Murphy, Vice President Membership and Professional Development
- Michael Giuliani, Sr. Director Legislation and Political Action
- Barry Ziman, Director Legislation and Political Action

Senior Staff Advisors

- John Scott, Vice President Advocacy and Policy
- George Fiedler, Sr. Vice President Capability and Specialty Advancement

PROPOSED GOALS:

- **Identify and review past efforts** *(what worked and what did not and why?)*
- **Identify current CAP activities focused on SPS**
- **Continue to promote state advocacy opportunities**
- **Promote cross-organizational membership**
- **Explore HOD-state pathology linkages**
- **Ensure that the relationship benefits both the CAP and State Pathology Societies**

* Define what future relationships will look like

Gateway to Leadership

CONTENTS OF THIS SECTION

2016 House of Delegates Steering Committee Elections:

- Timeline
- Candidate Form

2016 CAP Council and Committee Application

COLLEGE of AMERICAN PATHOLOGISTS

2016 Steering Committee Elections Timeline

Timing	Deadline	Activity
Q4 2015	October 3 HOD	OPEN: Call for Candidates Announce Steering Committee Elections at HOD Meeting
Q1 2016		Speaker appoints Nominating Committee
Q4 2015 Q1 2016		Communications sent to House members with information on how to apply to Steering Committee
Q2 2016	April 1, 2016	House members apply to Steering Committee
Q2 2016		Nominating Committee reviews candidates and determines slate
120 days out	May 20, 2016	Nominating Committee reports its slate of candidates to the House
90 days out	June 21, 2016	Deadline for nomination by petition
0 days out	September 24, 2016	House of Delegates Meeting
0 days out	September 24, 2016	Election of Steering Committee members – Members take office immediately following elections

325 Waukegan Rd.
Northfield, IL 60093
800-323-4040 | cap.org

CAP House of Delegates Steering Committee
Candidate Information Request Form

Name

Institution

Practice Manager's Name

Address

City State Zip

Daytime Telephone (include area code & extension) Fax

E-Mail

1. What position are you seeking for the 2014 – 2016 Steering Committee?

☐ Speaker*
☐ Vice Speaker*
☐ Secretary
☐ Sergeant-at-Arms
☐ Member-at-Large

**The positions of Speaker and Vice Speaker are ex-officio members of the CAP Board of Governors, and, as such, carry with them considerable time commitments. Candidates should be aware that this will include time away from the office.*

2. What is your primary practice type?

☐ Hospital laboratory
☐ Government service
☐ Private laboratory
☐ Industrial company
☐ Academic
☐ Other: _____

3. Are you a member of the State Pathology Society?

☐ Yes ☐ No

4. Are you a member of your State Medical Society?

☐ Yes ☐ No

5. Do you have any special interest, talents, or abilities (other than the practice of pathology) that would make you a valuable contributor to the House of Delegates?

☐ Communications
☐ Computers
☐ Education
☐ Fiscal
☐ Management
☐ Negotiating skills
☐ Political action
☐ Public relations
☐ Quality assurance
☐ Speaking ability
☐ Other: ____

Comments: _____

6. Please describe your positions in and contributions to the CAP House of Delegates (e.g., previous Steering Committee positions held, Action Group involvement, etc.)

Over, please

7. **Please describe your positions in and contributions to the College of American Pathologists (e.g., committee memberships, LAP inspections, etc.).**

8. **Please describe your positions in and contributions to your state pathology and/or medical society (e.g., offices held, committee memberships, etc.).**

9. **Why do you want to be a member of the House of Delegates Steering Committee?**

10. **If you are elected, what do you hope to accomplish?**

Deadline for submission: April 1, 2016

Email or FAX completed form to Jan Glas,

jglas@cap.org or 847.832.8499

COLLEGE of AMERICAN PATHOLOGISTS

College of American Pathologists (CAP) Member/ Non-Member Engagement Application

Name

Address City State ZIP

Telephone

Email address

CAP Member? ☐ No ☐ Yes CAP Member Number_____

INSTRUCTIONS: CAP member and non-member pathologists and/or laboratory professionals interested in immediate and future volunteer service on a CAP committee, project team, member survey panel, etcetera should submit a completed *CAP Member/Non-Member Engagement Application* [converted to a portable document format (pdf)] along with a current curriculum vitae (CV)[converted to a portable document format (pdf)] to CAP staff, Barbara J. Barrett, via email bbarret@cap.org.

Completed applications & CVs received on or before March 31, 2015 will be considered during the *2016 CAP Committee Appointment Process.*

Pathology residents taking their board certification examination in 2015, may use this application to apply for 2016 committee service. All other pathology residents should use the CAP Junior Member Committee Application (when it becomes available) to apply for a resident position on a CAP committee.

From the following choices, please check (√) no more than five (5) committees/project teams/etcetera that you may be interested in serving on.

Council on Membership and Professional Development

☐ Committee on Professional and Community Engagement
☐ Member Engagement Committee
☐ New In Practice Committee
☐ Practice Management Committee

Council on Government and Professional Affairs

☐ CAP Political Action Committee (PathPAC)
☐ Economic Affairs Committee
☐ Federal and State Affairs Committee

Council on Education

☐ Clinical Pathology Education Committee
☐ Curriculum Committee
☐ Graduate Medical Education Committee
☐ Publications Committee

Council on Scientific Affairs

- ☐ Accuracy Based Testing Committee
- ☐ Autopsy Committee
- ☐ Cancer Committee
- ☐ Cancer Biomarker Reporting Committee
- ☐ CAP/ACMG Biochemical & Molecular Genetics Resource Committee
- ☐ CAP/ACMG Cytogenetics Resource Committee
- ☐ Center Committee
- ☐ Chemistry Resource Committee
- ☐ Coagulation Resource Committee
- ☐ Cytopathology Committee
- ☐ Diagnostic Immunology Resource Committee
- ☐ Digital Pathology Committee
- ☐ Forensic Pathology Committee
- ☐ Hematology/Clinical Microscopy Resource Committee
- ☐ Histocompatibility/Identity Testing Committee
- ☐ Histotechnology Committee
- ☐ Immunohistochemistry Committee
- ☐ Informatics Committee (formerly the Diagnostic Intelligence and Health Information Technology (DIHIT) Committee)
- ☐ Instrumentation Committee
- ☐ In Vivo Microscopy Committee
- ☐ Microbiology Resource Committee
- ☐ Molecular Oncology Committee
- ☐ Neuropathology Committee
- ☐ Pathology Electronic Reporting (PERT) Committee
- ☐ Personalized Health Care Committee
- ☐ Point of Care Testing Committee
- ☐ Quality Practices Committee
- ☐ Reproductive Medicine Committee
- ☐ Standards Committee
- ☐ Surgical Pathology Committee
- ☐ Toxicology Resource Committee
- ☐ Transfusion Medicine Resource Committee

Council on Accreditation

- ☐ Accreditation Committee
- ☐ Accreditation Education Committee
- ☐ Biorepository Accreditation Program Committee
- ☐ CAP15189 Committee
- ☐ Checklists Committee
- ☐ Complaints and Investigations Committee
- ☐ Continuous Compliance Committee
- ☐ Inspection Process Committee

OTHER COMMITTEES/PROJECT TEAMS/OPPORTUNITIES

- ☐ International Venture Steering Committee
- ☐ Education Project Teams to develop educational programs
- ☐ Project Team to develop, review, and/or pilot test pathology practice tools
- ☐ I am interested in volunteering for a CAP opportunity other than those specifically indicated above.

1. Your primary practice is located at [(√) check only one]

- ☐ Academic Center with an ACGME pathology residency program
- ☐ Blood Center
- ☐ Commercial Laboratory
- ☐ Core Laboratory for Multiple Hospitals
- ☐ Forensic Lab/Autopsy Center
- ☐ Hospital/Medical Center
- ☐ Industry
- ☐ Military/Government Agency
- ☐ Physician Office Laboratory
- ☐ Private Laboratory
- ☐ Research Laboratory
- ☐ Stand Alone Laboratory
- ☐ Other _____

2. What is your primary position?

- ☐ Administrative Director
- ☐ Informatics Specialist/Director
- ☐ Laboratory Manager
- ☐ Medical Director
- ☐ Medical Technologist
- ☐ Non-Director Pathologist
- ☐ Pathology practice manager
- ☐ PhD Clinical Scientist
- ☐ POC Coordinator
- ☐ Quality Manager
- ☐ Supervisor
- ☐ Other _____

3. Including yourself, list the number of pathologists in your practice? _____

4. What year did you start practicing pathology following formal training? _____

5. What market type does your pathology practice serve? [(√) check only one]

- ☐ Large Metropolitan Area
- ☐ Rural
- ☐ Suburban
- ☐ Small Metropolitan Area
- ☐ Other _____

6. From the following list, please check (√) any subspecialty areas that are of interest to you.

- ☐ Blood Banking/Transfusion Medicine
- ☐ Biochemical Genetics
- ☐ Bone and Soft Tissue Pathology
- ☐ Breast Pathology
- ☐ Cardiovascular Pathology
- ☐ Chemical Pathology
- ☐ Clinical Informatics
- ☐ Cytogenetics
- ☐ Cytopathology
- ☐ Dermatopathology
- ☐ Forensic Pathology
- ☐ Gastrointestinal Pathology (GI)
- ☐ Genitourinary Pathology
- ☐ Gynecologic Pathology
- ☐ Head and Neck Pathology
- ☐ Histocompatibility
- ☐ Hematopathology
- ☐ Liver Pathology
- ☐ Medical Microbiology
- ☐ Molecular Genetic Pathology
- ☐ Molecular Pathology
- ☐ Neuropathology
- ☐ Oncologic Pathology
- ☐ Orthopedic Pathology
- ☐ Pediatric Pathology
- ☐ Pharmacogenomics
- ☐ Pulmonary Pathology
- ☐ Renal Pathology
- ☐ Reproductive Medicine
- ☐ Surgical Pathology
- ☐ Transplant Pathology
- ☐ Urologic Pathology
- ☐ Other _____

7. Do you have any special interests or expertise beyond the practice of pathology? If yes, then please check (√) all that apply from the list below.

- ☐ Accountable Care Organizations (ACOs)
- ☐ Advocacy
- ☐ Clinical Informatics
- ☐ Communications
- ☐ Continuous Quality Improvement (CQI)
- ☐ Education
- ☐ Finance
- ☐ Fund Raising
- ☐ Humanitarian/philanthropic activities
- ☐ Information Technology
- ☐ Languages: Fluent in a language other than American English (Please List _____)
- ☐ Marketing
- ☐ Management
- ☐ Patient Advocacy Group (Please List _____)
- ☐ Parliamentary Procedure
- ☐ Philanthropy
- ☐ Political action
- ☐ Public health
- ☐ Public relations/speaking
- ☐ Quality assurance
- ☐ Standards Development Organization Work
- ☐ Terminologies
- ☐ Other: _____

8. From the list below, please indicate other CAP initiatives/activities that you currently or previously participated in. Check (√) all that apply.

- ☐ Author (book, journal article, newsletter, etc.)
- ☐ Committee, Council, and/or Working Group Chair/Member
- ☐ Education Speaker
- ☐ Engaged Leadership Academy
- ☐ Engaged Leadership Network
- ☐ House of Delegates/Residents Forum
- ☐ LAP Inspector and/or team member # of Inspections Performed _____
- ☐ Member Survey Panels
- ☐ PathNet
- ☐ Other: _____

9. Have you previously submitted a CAP Member/Non-Member Engagement Application?

☐ No ☐ Yes If yes, indicate the year you submitted an application _____

10. Why are you interested in serving on a CAP committee/project team, etc?

11. What relevant expertise or abilities will you bring to enhance the work of these CAP committees/project teams/panels etc?

12. Describe any other community or professional activities that you feel would enhance your contribution to these CAP committees/project teams/panels, etc.

Please email your completed application [converted to a portable document format (pdf)] and your curriculum vitae [converted to a portable document format (pdf)] to

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Incomplete applications will not be considered. All submitted materials become the property of the CAP and will not be returned.

_____

Name (electronic signature is acceptable) Date

Thank you for your interest in serving on a CAP committee/workgroup/team/etc.

Reference Documents & Forms

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Rules of the House of Delegates

Revised March 2, 2013

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Rules of the House of Delegates

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Article I - Preamble

The House of Delegates of the College of American Pathologists is to provide representation of the membership of the various states, other geographic areas and special groups. The House of Delegates shall act as a forum representing members of the College of American Pathologists. It shall serve as the voice of member pathologists to the Board of Governors, College Councils, Commissions, and Committees. The House of Delegates shall solicit issues from the membership through Delegation Chairs, provide a forum to deliberate the issues, and send reports on the issues (action items) to the Board of Governors, College Councils, Commissions, and Committees. It shall receive reports of the activities of the Board of Governors, College Councils, Commissions, Committees and Action Groups, including reports on issues (action items) sent to the above groups. The House will report to the Board of Governors, College Councils, Commissions, Committees and Action Groups the effectiveness of these activities in meeting member needs. The House may initiate its own business and assume such other responsibilities as may be assigned by provisions in the Bylaws.

Article II - Membership

Section l: Requirement for membership and terms of office

(a) The House of Delegates shall be composed of Fellows of the College, elected or appointed, with an equal number of Delegates and Alternate Delegates.

(b) The election of Delegates and Alternate Delegates shall be conducted every third year.

(c) The terms of all Delegates and Alternate Delegates elected from any geographic area or appointed to a federal service delegation (Army, Navy, Air Force, Public Health Service and Veterans Affairs) shall be three years. Delegates or Alternate Delegates appointed to fill a vacant elective seat shall serve only the remaining portion of a term. Delegates and Alternates shall be eligible for re-election. Delegates and Alternates shall represent only their federal service or the geographic entity of their principal office. Upon removal of the Delegate's or Alternate's principal office to another state, district, territory, commonwealth or province, or separation from the federal service, the term shall be forfeited.

(d) Upon vacancy due to death, retirement, resignation, move from the area represented or separation from active federal service, the Speaker shall appoint a successor fulfilling the above requirements to complete the term.

Section 2: Apportionment

(a) The Chief Executive Officer will conduct an annual census on January 1, of the number of Fellows of the College of American Pathologists in each state, district, territory, commonwealth or province. The results of this census shall be certified to the Speaker and to the Secretary.

(b) Each state, district, territory, commonwealth or province shall be represented by one Delegate and Alternate Delegate for each fifty fellows of the College or any fraction of that number. Each federal service shall be represented by one Delegate and Alternate Delegate. States,

districts, territories, commonwealths or provinces with more than one Delegate may divide themselves into geographic areas with each Delegate and Alternate elected to represent an area. Where there are a large number of College members in a designated area, it may be necessary to have more than one Delegate and Alternate to represent that area. The Delegate and Alternate must have their principal place of practice in the area which they represent.

Section 3: Reapportionment

Reapportionment of membership shall not deny to any Delegate or Alternate Delegate, elected or appointed to a term of office, the right to complete that term.

Section 4: Nominations

(a) All Fellows of the College in good standing shall have the opportunity to nominate themselves for election as a Delegate.

(b) A list of all self-nominated Fellows from each geographic area will be forwarded to the pathology society of the appropriate state, district, territory, commonwealth or province for their endorsement of the candidate(s). If a state, district, territory, commonwealth or province is represented by more than one organized pathology society, each society may submit their endorsement. These societies may nominate additional candidates for election as a Delegate. State society presidents may serve as ex officio members of their state society delegation, if not already a member of the delegation. Candidates nominated by these societies must be vetted for CAP Fellow status and must accept the nomination. Non- CAP member candidates will be requested to complete membership requirements of the College of American Pathologists. Upon completion of membership requirements, the candidate will be considered for election as a Delegate. Any society not responding by the published deadline may lose their opportunity to endorse candidates.

(c) If there are no self-nominated candidates for a geographic area, and there is no properly organized or functioning pathology society in an area, the Speaker of the House shall directly nominate, or cause to be nominated, one or more Fellows of that geographic area.

(d) The federal services shall be forwarded the names of any interested Fellows in their service and shall be invited to recommend candidates for appointment.

(e) The Residents Forum shall be invited to nominate candidates for appointment of a Resident Delegate and Resident Alternate Delegate for a one-year term.

Section 5: Nominations from other nations

Fellows in other nations shall have the right to organize and to nominate Delegates and Alternate Delegates upon petition to the Board of Governors. When recognized, these national groups shall participate in elections and be entitled to proportional representation in a manner similar to states, districts, territories, commonwealths and provinces.

Section 6: Voting for Delegates and Alternate Delegates

Votes shall be cast by a secret ballot by Fellows practicing in a geographic area. After nominations have been made and the headquarters office properly informed of the endorsements by the societies, the headquarters office shall provide ballots to all Fellows eligible to vote no later than twenty-eight weeks prior to the CAP's Annual Meeting. Ballots should be returned to the headquarters office for tabulation of results within six weeks.

In accordance with the apportionment for each geographic area, those Delegates who receive the greatest amount of votes shall be the elected Delegates for that area. Those with next

greatest amount of votes shall fill the Alternate positions for that area. If there are more candidates than available positions, those candidates will be placed on a waiting list.

Section 7: Delegation Chairs
In any state, district, territory, commonwealth or province with more than one Delegate, a Delegation Chair shall be elected by vote of the members of the respective delegation. The respective delegation shall notify the national office of the College of the election results prior to the next Fall Meeting. The Chair of a Delegation will be responsible for seeing to the attendance of that Delegation and shall serve as the official contact between the Delegation and the College headquarters office.

Article III - Officers and Steering Committee

Section 1: Speaker
The principal officer of the House of Delegates shall be the Speaker who will preside at meetings, maintain order and decorum and appoint Committees/Action Groups of the House as set forth in these rules. The Speaker shall issue the official call for meetings. The Speaker, with the assistance of the Steering Committee, has the ultimate authority and responsibility for conducting House business in a thorough, effective and efficient manner. It is the responsibility of the Speaker, with the assistance of the Steering Committee, to insure that Issues (action items) are addressed by the House, reports sent to the Board of Governors, College Councils, Commissions and Committees and reports back are received and presented to the House in a timely manner. The Speaker shall update Delegates on business of the House on an ongoing basis, as appropriate The Speaker shall have the right to vote only in the case of a tie.

Section 2: Vice Speaker
The Vice Speaker shall be an officer of the House and shall act as the principal officer of the House in the absence of the Speaker. The Vice Speaker shall assist in the duties of the Speaker, and shall have the responsibility of overseeing the Delegation Chairs.

Section 3: Secretary
The Secretary shall be an officer of the House, shall be responsible for all records of the House of Delegates and shall ensure that all pertinent business is accurately and promptly recorded.

Section 4: Sergeants-at-Arms
Two Sergeants-at-Arms shall be officers of the House and shall assist the Speaker in maintaining order and in seeking members for a vote if a quorum is not present. They will act as a credentials committee for the admission of Delegates or Alternate Delegates to the floor of the House.

Section 5: Steering Committee
(a) A Steering Committee, composed of the officers of the House and two Delegates elected at large, shall act as an executive committee, conducting House business during the interval between House meetings.

(b) The Speaker shall serve as Chair of this Committee.

(c) The Steering Committee shall assist in preparing the agenda and in carrying out the activities of the House. It shall meet prior to each general meeting of the House and may meet at any time on the call of the Speaker.

Section 6: Term of Office

The Speaker, Vice Speaker, Secretary, the two Sergeants-at-Arms, and the two Members-at-Large of the Steering Committee shall be elected for a term of two years, in even numbered years, at the Fall Meeting of the House and in the manner provided for in these rules. Only duly-qualified Delegates may serve as officers and Steering Committee members. Members of the Steering Committee shall be eligible for re-election. The tenure of each office shall be no more than two (2) full terms. Appointment for election to a partial term of office shall not be a consideration of such tenure.

Section 7: Succession

(a) If the Speaker dies, resigns, is removed from office or is otherwise unable to serve, the Vice Speaker shall assume the office, responsibilities, and duties of the Speaker and serve for the remainder of the unexpired term. If any other officer of the House dies, resigns, is removed from office or is otherwise unable to serve, a successor shall be appointed by the Speaker from the elected members of the Steering Committee to serve for the remainder of the unexpired term. Vacancies occurring in the position of Member-at-Large to the Steering Committee shall be filled by appointment by the Speaker for the duration of term.

(b) If the offices of the Speaker and Vice Speaker are simultaneously vacant, the Secretary of the House shall assume the office, duties and responsibilities of the Speaker. At the next meeting of the House of Delegates, the unexpired terms of the Speaker and the Vice Speaker shall be filled by election or special election as appropriate.

(c) In the event of the simultaneous vacancies of the offices of Speaker, Vice Speaker and Secretary, the President of the College of American Pathologists shall appoint a temporary presiding officer from the remaining members of the Steering Committee, to conduct the business of the House until such vacancies are filled by election or special election as appropriate.

Article IV - Elections

Section 1: Method of Election

(a) During the first quarter in even-numbered years, the Speaker shall appoint a Nominating Committee to serve until the Fall Meeting at which time the Steering Committee elections will be held.

(b) (1) The nominating committee shall be composed of five (5) Delegates or Alternate Delegates who will consider candidates, as prescribed herein, for vacancies in the offices of the House and/or House Steering Committee positions.

(2) With the exception of the Nominating Committee Chair, Delegates and Alternate Delegates are eligible to serve on the Nominating Committee no more than once every three years. The Speaker of the House shall choose the House Nominating Committee Chair from the membership of the previous Nominating Committee. No one may serve as Chair on two successive Nominating Committees.

(3) The Nominating Committee may select eligible candidates as it deems necessary to ensure balanced representation of the House of Delegates. The geographic distribution, practice patterns, and sub-specialties of candidates should be taken into account. The Nominating Committee should strongly consider candidates who have actively participated in House functions and deliberations.

(4) Delegates not concurrently seeking election as officers or governors of the College are eligible for consideration by the House of Delegates Nominating Committee. A Delegate who seeks nomination to a House office shall waive all rights under Article V, Section 2,

Item B of the CAP Constitution to seek nomination, appointment, or election to the Board of Governors during the concurrent period of House nominations and elections.

(5) The Nominating Committee may at its discretion interview candidates for any position. If it determines to interview any candidate for a position, it shall interview all candidates for that position. If the Committee determines to hold in-person interviews for a position, the College shall pay the reasonable expenses of each candidate for that position. The Nominating Committee will report its slate of candidates to the Speaker of the House, all members of the House, and the President of the College, 120 days prior to the Fall Meeting. The Chair of the Nominating Committee will notify candidates of its selection.

(6) Additional nominations for House office may be made by signed petition of at least twenty (20) Delegates or Alternates submitted to the Chief Executive Officer no later than ninety (90) days before the Fall Meeting of the House of Delegates. Candidates seeking nomination by petition shall be qualified as in Article IV, Section I (b) (4) above.

(c) The Delegates shall have the opportunity to nominate additional candidates from the floor at the Fall Meeting.

Section 2: Installation

(a) Upon the determination of the elected candidates for office, the Speaker shall present the newly-elected officers and Members-at-Large of the Steering Committee to the House.

(b) The term of office of those elected shall begin at the time of adjournment of the Fall Meeting of the House.

(c) In the event of a special election, the term of office of those elected will begin upon election and will continue until the next regularly scheduled election.

Section 3: Special Election

(a) A special election to elect a Speaker and Vice Speaker shall be held at the next regularly scheduled House of Delegates meeting if both offices become simultaneously vacant and if no regularly prescribed election has been scheduled. The nominees for each office shall be named by the nominating committee, appointed in conformity with Article IV, Section 1.

(b) Should such vacancies occur between regularly scheduled meetings of the House of Delegates, notification of such special election shall be in conformity with Article IV, Section 1. If such simultaneous vacancies occur within thirty (30) days of the next regularly scheduled House of Delegates meeting or during the House of Delegates meeting, the requirement for thirty (30) days advance notice by the nominating committee shall be waived provided the House is given the maximum notification practical.

Article V - Procedure of Meetings

Section I: Meetings

(a) The House of Delegates shall meet in conjunction with the Stated Annual Meeting of the College of American Pathologists and may hold a second meeting during spring each year. Meetings of the House shall be open to all CAP members. However, the House may hold executive sessions.

(b) The House of Delegates may be called for special meetings by the Speaker.

(c) Upon petition of thirty members of the House, the Speaker shall notify the Board of Governors and shall call a special meeting of the House within a period of sixty days, said meeting to be held by interactive technology or in the same general area in which the headquarters office of the College of American Pathologists is located.

(d) The purpose and agenda of such special meetings shall be submitted with the call.

Section 2: Registration

(a) Before being seated at any session, each Delegate or Alternate shall present credentials and be recognized by the credentials Committee.

(b) When a Delegate is unable to attend a specified session, an Alternate from the Delegation will substitute for that Delegate. Only duly elected Delegates or Alternates may be seated at any session of the House of Delegates unless the Chief Executive Officer of the College has been given due notice by the Chair of said delegation, of emergency substitution at that assembly, seven (7) days prior to the meeting. Only Fellows of the College are eligible for such emergency substitution. In the event that the Delegate or Alternate from the Residents Forum is not able to participate in a given meeting, the Residents Forum Executive Committee may designate an appropriate replacement from among the Junior Members in accordance with the above procedure.

(c) If a Delegate's seat is not filled by either the Delegate or an Alternate for two consecutive meetings, the Speaker shall declare the position vacant and fill the vacancy by appointing a Fellow of the College under the provision of Article II. Section 1(d).

Section 3: Order of business

The official order of business of the House will be published in the Delegates' agenda book. The agenda book will be available to members of the House prior to the House meeting. The introduction of new business at the meeting will require a two-thirds majority vote.

Section 4: Quorum

Representation at the meeting by a majority of current delegations shall constitute a quorum.

Section 5: Vote

Unless otherwise specified in these rules, all questions proposed for consideration by members of the House of Delegates shall be determined by a majority of votes of those present and eligible to vote. Unless a matter is determined by ballot, a declaration by the presiding officer that an action item has been carried shall be sufficient evidence of the fact.

Section 6: Privileges of officers and governors of the College

Officers of the College, members of the Board of Governors and Past Presidents of the College shall have all privileges of the House but may not hold House office, vote or serve on committees.

Section 7: Disposition of action

All action items, and reports of the House of Delegates shall be presented by the Speaker to the Board of Governors at its next regular meeting. If a Speaker is unable to act, the Vice Speaker or Secretary shall carry out this duty.

Section 8: Rules of order

(a) The House of Delegates shall be guided in its actions by the Constitution and Bylaws of the College of American Pathologists and these rules of the House of Delegates.

(b) When not in conflict with these rules or the Constitution and Bylaws of the College, the standard for parliamentary procedure accepted by the College shall govern the conduct of the meetings of the House. The Speaker reserves the right to accept a motion to dismiss parliamentary procedure for meetings of the House.

Article VI - Business of the House of Delegates

Section 1: Action Items

(a) Action Items may be submitted by any Delegate or member of the Board of Governors. It is the responsibility of the Delegation Chairs to solicit constituent member pathologists for issues (action items) prior to the Spring meeting of the House of Delegates. The manner in which this is accomplished is at the discretion of the Delegation Chair and may be done electronically or otherwise. The Speaker will solicit issues (action items) from each Delegation Chair prior to the Spring House meeting. The manner in which this is accomplished is at the discretion of the Speaker. These issues (action items) will be reviewed by the Speaker and the House Steering Committee, and compiled as part of the House agenda.

(b) The Action Item must be in written form and must be in the hands of the Speaker or submitted to the Chief Executive Officer of the College not later than the published deadline three weeks prior to the House meeting.

(c) The Steering Committee will review all action items submitted later than the published deadline to determine whether they shall be presented to the House. Late action items will be referred for consideration by the House only when they are:
1. accepted by two-thirds consent, or
2. of an urgent nature, or
3. submitted by the Board of Governors, or
4. submitted by the Residents Forum.

Section 2: Committees/Action Groups

The Speaker reserves the right to appoint HOD Committees/Action Groups as appropriate to address a specific issue of business. Committees/Action Groups are composed of Delegates selected by the Speaker to meet by teleconference between meetings or conduct open hearings on matters of business of the House.

Section 3: Other Committees/Action Groups

The Speaker may appoint such additional Committees/Action Groups as are needed from time to time to conduct the business of the House.

Section 4: Reports of Action Items

Reports of all action items of the House of Delegates are sent to the Board of Governors and to College Councils, Commissions and Committees as appropriate. The House of Delegates will receive a report back on all action items sent no later than the next meeting of the House. The House may request a report back at a finite time prior to the next House meeting, provided that the requested time is congruent with internal CAP scheduling.

Article VII - Amendments

Section 1:
During the first quarter following House office elections, these rules will be reviewed. These rules may be amended on the approval of two-thirds of the members of the House, provided that written notice of the proposed changes is given to Delegates at least thirty days prior to voting. Votes may be cast electronically or by other method as appropriate at the discretion of the Speaker.

House of Delegates
2015 Apportionment

	Total # of Fellows	# of Delegate Seats	# of Alternate Seats	# of Delegates Appointed	# of Alternates Appointed	# of Delegate Vacancies	# of Alternate Vacancies	# of Wait Listed
Alabama	191	4	4	4	4	0	0	0
Alaska	28	1	1	1	1	0	0	0
Arizona	297	6	6	4	0	2	6	0
Arkansas	117	3	3	3	3	0	0	5
California	1454	30	30	21	0	9	30	0
Colorado	243	5	5	4	1	1	4	0
Connecticut	234	5	5	4	0	1	5	0
Delaware	39	1	1	1	1	0	0	2
District of Columbia	44	1	1	1	1	0	0	0
Florida	975	20	20	19	7	1	13	0
Georgia	353	8	8	7	7	1	1	0
Guam	3	1	1	0	0	1	1	0
Hawaii	58	2	2	2	2	0	0	0
Idaho	40	1	1	1	0	0	1	0
Illinois	658	14	14	13	5	1	9	0
Indiana	288	6	6	6	0	0	6	0
Iowa	152	4	4	3	3	1	1	0
Kansas	144	3	3	3	0	0	3	0
Kentucky	176	4	4	3	0	1	4	0
Louisiana	210	5	5	3	1	2	4	0
Maine	80	2	2	0	0	2	2	0
Maryland	346	7	7	4	0	3	7	0
Massachusetts	453	10	10	9	9	1	1	0
Michigan	481	10	10	10	1	0	9	0
Minnesota	261	6	6	5	0	1	6	0
Mississippi	99	2	2	1	0	1	2	0
Missouri	321	7	7	6	5	1	2	0
Montana	41	1	1	1	1	0	0	0
Nebraska	109	3	3	3	2	0	1	0
Nevada	90	2	2	0	0	2	2	0
New Hampshire	81	2	2	2	1	0	1	0
New Jersey	387	8	8	8	2	0	6	0
New Mexico	117	3	3	1	0	2	3	0
New York	878	18	18	16	0	2	18	0
North Carolina	424	9	9	9	5	0	4	0
North Dakota	33	1	1	1	0	0	1	0
Ohio	596	12	12	12	7	0	5	0
Oklahoma	127	3	3	3	2	0	1	0
Oregon	165	4	4	3	0	1	4	0
Pennsylvania	702	15	15	13	0	2	15	0
Puerto Rico	54	2	2	2	0	0	2	0
Rhode Island	71	2	2	0	0	2	2	0
South Carolina	202	5	5	4	2	1	3	0
South Dakota	54	2	2	1	1	1	1	1
Tennessee	378	8	8	8	2	0	6	0
Texas	1104	23	23	21	9	2	14	0
Utah	120	3	3	3	0	0	3	0
Vermont	51	2	2	1	1	1	1	1
Virgin Islands	1	1	1	0	0	1	1	0
Virginia	338	7	7	7	3	0	4	0
Washington	335	7	7	7	7	0	0	1
West Virginia	81	2	2	2	1	0	1	0

House of Delegates
2015 Apportionment

	Total # of Fellows	# of Delegate Seats	# of Alternate Seats	# of Delegates Appointed	# of Alternates Appointed	# of Delegate Vacancies	# of Alternate Vacancies	# of Wait Listed
Wisconsin	280	6	6	6	0	0	6	0
Wyoming	21	1	1	0	0	1	1	0
Canada								
Alberta	49	1	1	0	0	1	1	0
British Columbia	32	1	1	0	0	1	1	0
Manitoba	9	1	1	1	0	0	1	0
New Brunswick	9	1	1	0	0	1	1	0
Newfoundland	8	1	1	0	0	1	1	0
Nova Scotia	4	1	1	0	0	1	1	0
Ontario	18	1	1	1	1	0	0	0
Prince Edward Island	1	1	1	0	0	1	1	0
Quebec	3	1	1	0	0	1	1	0
Saskatchewan	14	1	1	0	0	1	1	0
Other Delegations								
Residents Forum		1	1	1	1	0	0	0
US Army		1	1	1	0	0	1	0
US Veteran Affairs		1	1	0	0	1	1	0
US Navy		1	1	1	1	0	0	0
US Air Force		1	1	0	0	1	1	0
Total Seats		**335**	**335**	**277**	**100**	**58**	**235**	**10**
		DEL SEATS	ALT SEATS	DELS APPT	ALTS APPT	OPEN DELS	OPEN ALTS	WAITLIST

Key House of Delegates Dates

2015	
Monday, March 23	Spring ’15 HOD Post-Meeting Survey
Tuesday, March 31	**Deadline**: 2016 CAP Council/Committee Application
Tuesday, March 31	**Deadline**: 2016 CAP Meritorious Awards Nomination
Thursday, April 2 – Thursday, April 16	HOD College Report Card Survey
Monday-Wednesday, May 4-6	CAP 2015 Policy Meeting, Washington, DC
Friday, September 4	**Deadline**: HOD/CAP ’15 Housing
Saturday, October 3	Fall ’15 House of Delegates Meeting, Nashville
October 3	Open Call for HOD Steering Committee Candidates Communication to HOD members regarding Steering Committee nomination process and elections
Sunday- Wednesday, October 4-7	CAP ’15 – THE Pathologists’ Meeting, Nashville
2016	
March	Communication to HOD members regarding Steering Committee nomination process and elections
Saturday, March 12	Spring ’16 House of Delegates Meeting, Seattle
Friday, April 1	**Deadline**: HOD members nominate for Steering Committee
Monday-Wednesday, May 2-4	CAP 2016 Policy Meeting, Washington, DC
Friday, May 20	Nominating Committee announces its slate for HOD Steering Committee
Tuesday, June 21	**Deadline**: for HOD Steering Committee nomination by petition
Saturday, September 24	Fall ’16 House of Delegates Meeting, Las Vegas HOD Steering Committee elections

Residents Forum Delegate Roster

First Name	Last Name	Credentials with FCAP	State	Email Address	Committee Role Type
Atin	Agarwal	MD	TX	aagarwal@bcm.edu	Delegate
Shweta	Agarwal	MD,MBBS	OK	shweta-agarwal@ouhsc.edu	Delegate
Diana	Agostini-Vulaj	DO	NY	dianaaagostini@gmail.com	Delegate
Felicia	Allard	MD	MA	fallard@bidmc.harvard.edu	Delegate
Mary-Margaret	Allen	MD	TN	mary-margaret.l.allen@vanderbilt.edu	Delegate
Rebecca	Allred	MD	UT	rebecca.allred@hsc.utah.edu	Delegate
Omar	Al-Nourhji	MD	MO	alnourhji@hotmail.com	Delegate
Rami	Al-Rohil	MBBS	NY	rami.rohil84@gmail.com	Delegate
Maria	Alvi	MD	TX	maria.alvi@gmail.com	Delegate
Anand	Annan	MD,MBBS	OK	anand-annan@ouhsc.edu	Delegate
Ronald	Araneta	MD	CT	ronald.araneta@hhchealth.org	Delegate
Jordan	Arkin	MD	NY	joa9097@nyp.org	Delegate
Hanan	Armanious	MD		armaniou@ualberta.ca	Delegate
Vaidehi	Avadhani	MD	NY	vavadhani@chpnet.org	Delegate
Sabina	Babayeva	MD	NY	sabinanb@gmail.com	Delegate
Raisa	Balbuena-Merle	MD	PR	raisa.balbuena@upr.edu	Delegate
Matthew	Ball	DO,MS	OH	matthew.ball@osumc.edu	Delegate
Whitney	Banks	DO		wbanks@gwu.edu	Delegate
Amber	Berning	MD	CO	amber.berning@ucdenver.edu	Delegate
Alexander	Berrebi	MD	MD	aberrebi@umm.edu	Delegate
Melissa	Blessing	DO	MN	blessing.melissa@mayo.edu	Delegate
Summer	Blount	MD,MT(ASCP)	CA	sblount@llu.edu	Delegate
Brian	Bockelman	MD	FL	bcbockelman@yahoo.com	Delegate
Jesse	Bond	MD,BSc	NH	jesse.s.bond@hitchcock.org	Delegate
Nora	Bowers		IL	nbowers@cap.org	Staff
Brian	Brinkerhoff	MD	OR	brinkerb@ohsu.edu	Delegate
Ryanne	Brown	MD	CA	rbrown85@stanford.edu	Delegate
Bronwyn	Bryant	MD	WA	bhbryant@gmail.com	Delegate
Tatiana	Buhtoiarova	MD	NJ	dr.buhtoiarova@gmail.com	Delegate
Shannon	Butler-Williams	MD	SC	butlerws@musc.edu	Delegate
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Carla	Caruso	MD	PA	ccaruso3@hmc.psu.edu	Delegate
Terra	Cederroth	MD	MA	tcederro@bidmc.harvard.edu	Delegate
Benjamin	Chamberlain	MD	TN	benjamin.k.chamberlain@vanderbilt.edu	Delegate
Nathan	Charles	MD	WI	ncharles@uwhealth.org	Delegate
Sonja	Chen	MD,MBBS	RI	schen3@lifespan.org	Delegate
Eunice	Choi	MD	TX	ekchoi@houstonmethodist.org	Delegate
David	Chou	MD	MA	dchou2@partners.org	Delegate
Bonnie	Choy	MD		bonnie.choy@uchospitals.edu	Delegate
Andrew	Chu	MD	TX	Andrew.chu@baylorhealth.edu	Delegate
Betty	Chung	DO,MPH,MA	NJ	chungbm@rwjms.rutgers.edu	Delegate
Adela	Cimic	MD	NY	adc9038@med.cornell.edu	Delegate
Rashna	Clubwala Meuiner	MD	RI	rashna55@gmail.com	Delegate
David	Cohen	MD	TX	dacohen@houstonmethodist.org	Delegate
Ryan	Collins	MD	PA	collinsra2@upmc.edu	Delegate
Diane	Cosner	MD	MI	diane.cosner@beaumont.edu	Delegate

Residents Forum Delegate Roster

First Name	Last Name	Credentials with FCAP	State	Email Address	Committee Role Type
Areli Karime	Cuevas-Ocampo	MD	MA	areli.cuevasocampo@baystatehealth.org	Delegate
Richard	Danialan	DO	TX	rdanialan@clpct.com	Delegate
John	Daniels	DO,JD,MBA,MPH	TX	danielsJ@uthscsa.edu	Delegate
Y	Delores Mo	MD	VA	delores.mo@virginia.edu	Delegate
Robert	DeSimone		NY	rod9096@nyp.org	Delegate
Christina	Dicarlo	MD	PA	cdicarlo@wpahs.org	Delegate
Tsetan	Dolkar	MD	CT	Tsetan.Dolkar@wcthealthnetwork.org	Delegate
Supriya	Donthamsetty	DO,MPH	LA	sdont1@lsuhsc.edu	Delegate
Buu	Duong	MD	LA	buutduong@gmail.com	Alternate
Ellen	East	MD	MI	easte@med.umich.edu	Delegate
Jill	Eickhoff	MD	KY	japa232@uky.edu	Delegate
Brent	Enniss	MD,DO	TX	brent.a.enniss.mil@mail.mil	Delegate
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Angie	Foster	MD	MO	aearhart@path.wustl.edu	Delegate
Andrew	Freeman	DO	MO	afreem14@slu.edu	Delegate
Maren	Fuller	MD	TX	myfuller@houstonmethodist.org	Delegate
Manoj	Gadara	MD	CT	manoj.gadara@hhchealth.org	Delegate
Jonathan	Galeotti	MD,MS	NC	jonathan.galeotti@duke.edu	Delegate
Pallavi	Galera	MD	MA	Pallavi.Galera@umassmemorial.org	Delegate
Daniel	Gehlbach	DO,MS	TX	daniel.gehlbach@phhs.org	Delegate
Alan	George	DO,BS	TX	alan.a.george@us.army.mil	Delegate
Jacqueline	Golden	MD	MA	gmgolden@partners.org	Delegate
Adam	Gomez	MD	CA	ajgomez@stanford.edu	Delegate
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Tesha	Guillory	MD	GA	tesha.guillory@emory.edu	Vice Chair
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Jennifer	Ha	MD	OH	jennifer.ha@uhhospitals.org	Delegate
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Bridget	Herschap	MD	TX	herschap@uthscsa.edu	Delegate
Maria	Hintzke	MD	WI	mhintzke@mcw.edu	Delegate
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Niloufar	Hosseini	MD		nfhosseini@gmail.com	Delegate
Yan	Hu	MD,PhD	NY	yanhu@buffalo.edu	Delegate
Julie	Huss	MD,BS	CA	jhuss@mednet.ucla.edu	Delegate
Ioannis	Ioannidis	MD	AL	ycioannidis@gmail.com	Delegate
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Residents Forum Delegate Roster

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Rahul	Jawale	MBBS	MA	drjawalerahul@gmail.com	Delegate
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Shuying	Ji	MD,PhD		jishuying@yahoo.com	Delegate
Amy	Joehlin-Price	MD	OH	Amy.Joelin-Price@osumc.edu	Delegate
Amy	Joiner	MD	AR	AKJoiner@uams.edu	Delegate
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Zarine	Kamaluddin	MD	OH	zarine_k_s@yahoo.com	Delegate
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Kanchan	Kantekure		MA	kanchankerur@gmail.com	Delegate
Adnan	Karavelic	MD		a.karavelic@gmail.com	Delegate
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Muhammad	Khurram	MD	MI	muhammad.khurram@stjohn.org	Delegate
Linda	Kocovski	MD,MBBS	ON	Linda.kocovski@medportal.ca	Delegate
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Brent	Larson	DO	CA	brent.larson@cshs.org	Delegate
Lik Hang	Lee	MD		LikHang.Lee@cls.ab.ca	Delegate
Daniel	Levitan	MD,BSc	NY	daniel.levitan@downstate.edu	Delegate
Natasha	Lewis	MD	IL		Delegate
Maria Cecilia	Lezcano Lopez		PA	lezcanolopezm@upmc.edu	Delegate
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Miao	Lu	MD		vivianlumiao@yahoo.ca	Delegate
Miao	Lu	MD		vivianlumiao@yahoo.ca	Delegate
Seth	Lummus	DO	CO	seth.lummus@ucdenver.edu	Delegate
Nicholas	Mackrides	MD	FL	n.mackrides@med.miami.edu	Delegate
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Shakuntala	Mauzo	MD,MBBS	TX	Shakuntala.H.Mauzo@uth.tmc.edu	Delegate
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Residents Forum Delegate Roster

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Sadaf	Memon			sadaf.memon@medportal.ca	Delegate
Ricardo	Mendoza	MD,MS,CT(ASCP)	VA	rmm360@gmail.com	Immediate Past Chair
Jill	Miller	MD	VT	jill.miller@vtmednet.org	Delegate
Rebecca	Millius	MD	AZ	rmillius@email.arizona.edu	Delegate
Leili	Mirsadraei	MD	CA	lmirsadraei@ucsd.edu	Delegate
Lauren	Murer	MD	NE	lauren.murer@unmc.edu	Delegate
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Hany	Osman	MD	IN	osmanh@iupui.edu	Delegate
Shobha	Parajuli	MD	PA	shobha.parajuli@tuhs.temple.edu	Delegate
Kirtesh	Patel	MD	SC	patekh@musc.edu	Delegate
Vatsal	Patel		FL	vatsalpatel@ufl.edu	Delegate
Spencer	Paulson	MD	AZ	spencerpaulson@email.arizona.edu	Delegate
Joseph	Peevey	MD	IL	joseph.peevey@northwestern.edu	Delegate
Ashley	Porter	MD	TN	aoldham2@uthsc.edu	Delegate
Michael	Prochaska	MD	PA	michael.prochaska@drexelmed.edu	Delegate
Patricia	Raciti	MD	NY	pr2392@columbia.edu	Delegate
Prachi	Raut	MD	MN	prachee.raut@gmail.com	Delegate
Deepti	Ravi	MD	OH	Deepti.Ravi@medportal.ca	Delegate
Bryan	Rea	MD,BS	PA	bryan.rea@uphs.upenn.edu	Delegate
Justin	Richey	MD	IN	jdrichey@iupui.edu	Secretary
Elizabeth	Rinehart	MD,BA	MA	erinehart@partners.org	Member
Evans	Roberts		LA	erobert5@tulane.edu	Delegate
Carrie	Robinson	MD	MD	carrie.robinson@med.navy.mil	Delegate
Thomas	Rogers	MD	VT	Thomas.Rogers@uvmhealth.org	Delegate
Ryan	Romano	DO	MN	romano.ryan@mayo.edu	Delegate
Jason	Rosen	DO	NY	jrosen@winthrop.org	Delegate
Jason	Rosenbaum	MD	WI	JRosenbaum@uwhealth.org	Delegate
Julia	Ross	MD,PhD,BS	CT	julia.ross@yale.edu	Delegate
Ana	Ruano	MD	OH	ruanoma@ccf.org	Delegate
Patrick	Rush	MD	WI	prush@uwhealth.org	Delegate
Samah	Saharti	MD	CA	sahrtsn@hotmail.com	Delegate
Ali	Sakhdari	MD	MA	ali.sakhdari@umassmemorial.org	Delegate
Siavash	Samimi	MD	CA	Siavash.AzadmaneshSamimi@cshs.org	Delegate
Joseph	Sanfrancesco	MD	OH	sanfraj@ccf.org	Delegate

Residents Forum Delegate Roster

First Name	Last Name	Credentials with FCAP	State	Email Address	Committee Role Type
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Erica	Savage	MD	IA	erica-savage@uiowa.edu	Delegate
Christopher	Sebastiano	MD	NY	sebastic@mskcc.org	Delegate
Robert	Seifert	MD	FL	seifert.md@gmail.com	Delegate
Seema	Sethi	MD	MI	drsethi7@gmail.com	Delegate
Divya	Sharma	MD,ACP	OH	sharmadi@UCMAIL.UC.EDU	Delegate
Rong	Shen	MD	VA	rong.shen@gunet.georgetown.edu	Delegate
Shweta	Shinagare	MD	MA	sshinagare@tuftsmedicalcenter.org	Delegate
Tracy	Shipe	DO	VA	tspath84@gmail.com	Delegate
Hemlata	Shirsat	MD		shirsat.h@dal.ca	Delegate
Ayaka	Silverman	MD,PhD	CA	amsilver@uci.edu	Delegate
Ayaka	Silverman	MD,PhD	CA	amsilver@uci.edu	Delegate
Anthony	Simms	MD	NY	Anthony.Simms@nyumc.org	Delegate
Hillary	Sims	MD	MS	hwsims@umc.edu	Delegate
Bart	Singer	MD	NC	bartsinger@gmail.com	Delegate
Namita	Sinha	MD		drnamitasinha1@gmail.com	Delegate
Joni	Skipper	MD	NC		Delegate
Vivian	Snyder	DO	IL	vsnyder@northshore.org	Delegate
Thomas	Soike	MD	SC	soike@musc.edu	Delegate
Abha	Soni	DO,MPH	AL	abhasoni@uabmc.edu	Delegate
Melissa	Stalling	DO,MS	OH	stallim2@ccf.org	Delegate
Anne	Stowman	MD	VA	AMS2ZP@virginia.edu	Delegate
Lauren	Stuart	MD,MBA	GA	lauren.stuart@emory.edu	Chair
Lacey	Sullivan	MD	LA	lsulliva@tulane.edu	Delegate
Kieran	Sultan	MD	CO	kieransultan@centura.org	Delegate
Lauren	Sumida	MD	HI	sumidal@hawaii.edu	Delegate
Ashwyna	Sunassee	MD	SD	ash.sunassee@yahoo.com	Delegate
Ashley	Tarasen	MD	NY	tarasea@mail.amc.edu	Delegate
Maria	Torres	MD	AZ	maria.torres3@dignityhealth.org	Delegate
Jessica	Tracht		AL	jtracht@uab.edu	Delegate
Humberto	Trejo Bittar		PA	trejobittarhe@upmc.edu	Delegate
Hamilton	Tsang	MD	NY	hat9010@nyp.org	Delegate
Louis	Vaickus	MD	MA	lvaickus@partners.org	Delegate
Kavita	Varma	MD	MI	kvarma1@hfhs.org	Delegate
Puneeta	Vasa	MD	GA	pvasa@gru.edu	Delegate
Jaylou	Velez-Torres		FL	jveleztorres@med.miami.edu	Delegate
Meggen	Walsh	DO	KY	meggen.walsh@uky.edu	Alternate
Qi	Wang	MD	LA	qwang3@lsuhsc.edu	Delegate
Rebecca	Waters	MD,DO	TX	reewater@utmb.edu	Delegate
Jaclyn	Watkins	MD	MA	jcwatkins@partners.org	Delegate
Whitney	Wedel	MD	NE	whitney.wedel@unmc.edu	Delegate
Wheeler	Weyant	MD	PA	gweyant@hmc.psu.edu	Delegate
Emily	Wilding	MD	MD	ewilding@umm.edu	Delegate
Kimberly	Williams	DO	PA	kimberly.williams2@uphs.upenn.edu	Delegate
Lindsay	Williams	MD	MI	linzalula@gmail.com	Delegate
Marcus	Winkler	DO	TN	mwinkler@utmck.edu	Delegate
Willard	Wong	MD,MBBS		willardwong@hotmail.com	Delegate

Residents Forum Delegate Roster

First Name	Last Name	Credentials with FCAP	State	Email Address	Committee Role Type
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Richard	Wu	MD,PhD	MI	rwu@med.wayne.edu	Delegate
Ling	Yan	MD,PhD	OR	yali@ohsu.edu	Delegate
Maggie	Yell	MD	WV	mayell@hsc.wvu.edu	Delegate
Christine	Yoo	MD	MD	cyoo@umm.edu	Delegate
Marci	Zerante		IL	mzerant@cap.org	Staff

COLLEGE of AMERICAN PATHOLOGISTS

Nomination Form Instructions

2015
CAP Meritorious Service Awards Program

To Acknowledge Outstanding Achievements and Accomplishments

Open Call for Nominations
Deadline *Extended*

March 31, 2015

Submit nominations via email to:

Barbara J. Barrett, MPA, CAE, MT(ASCP)
CAP Coordination Manager,
Membership and Professional Development
Email: bbarret@cap.org

2015 CAP Meritorious Service Awards Program
Nomination Form Instructions
About the Awards

- ***CAP Award for Specialty Advancement***

This award, established in 2013, recognizes innovation and perseverance resulting in the advancement of pathology and laboratory medicine through foresight, resolve and untiring commitment to both evolutionary and revolutionary undertakings that advance the positioning of the pathologist in the House of Medicine and delivery of safer patient care. Nominees may be CAP members, non-members, teams, staff, or an outside entity.

- ***CAP Distinguished Patient Care Award***

This award was established in 2006 to recognize and honor a member of the College who has made an outstanding contribution to patient care. It recognizes behavior that when emulated enhances the practice of pathology. *Nominees must be CAP members.*

- ***CAP Distinguished Service Award***

This award, established in 1965 (and amended in 2006), recognizes outstanding contributions to the practice of pathology and to the College of American Pathologists. *Nominees must be CAP members.*

- ***CAP Lifetime Achievement Award***

This award, established in 2006, recognizes and honors members of the College who have made a broad and positive impact on the pathology profession through contributions to one or more area(s) of the College over an extended period of time, but who have never received a CAP award. This award may be presented to more than one College member in a particular year. *Nominees must be CAP members.*

- ***CAP Outstanding Communicator Award***

This award, established in 1991, recognizes outstanding contributions in the area of communications resulting in the strengthening of the image of pathology. *Nominees may be CAP members, non-members, or staff.*

- ***CAP Public Service Award***

This award, established in 1989, recognizes accomplishments and dedication to political and civic life and to public service in the United States. *Nominees must be CAP Fellows.*

- ***CAP Resident of the Year Award***

This award was established in 2010 to recognize outstanding contributions by a CAP Junior Member to the specialty of pathology, to pathologists, to laboratory medicine, and/or to the general public. *Nominations for the CAP Resident of the Year Award only may be submitted by a CAP member.*

- ***CAP Staff Outstanding Achievement Award – New for 2015***

This award, established in 2014, recognizes CAP staff who have made a significant and positive impact in support of the College and its members, either through one or more noteworthy programs/projects, or a sustained history of going above and beyond in support of the College and its members. Nominations only may be made by College members or senior CAP staff (VP and above) and are limited to current staff working for the Collage at the time of receipt.

2015 CAP Meritorious Service Awards Program
Nomination Form Instructions
How to Submit a Nomination

Eligibility

1. Nominations for the CAP Meritorious Service Awards listed below should be submitted using a *2015 CAP Meritorious Service Awards Program Nomination Form.*
   - o *CAP Award for Specialty Advancement*
   - o *CAP Distinguished Patient Care Award*
   - o *CAP Distinguished Service Award*
   - o *CAP Lifetime Achievement Award*
   - o *CAP Outstanding Communicator Award*
   - o *CAP Public Service Award*
   - o *CAP Resident of the Year Award*
   - o *CAP Staff Outstanding Achievement Award*
2. For most awards, an individual or a group of individuals such as a team may be nominated. An individual or a group of individuals may be nominated for more than one award but ONLY recommend one individual or group of individuals per form.
3. Currently serving CAP officers, board members, or candidates for any elected CAP office ***are not eligible*** for an award nomination.
4. On or before March 31, 2015, please complete and submit via email a *2015 CAP Meritorious Service Awards Program Nomination Form* along with the nominee's curriculum vitae (CV) or the nominees' curricula vitae (CVs) to:

   Barbara J. Barrett, MPA, CAE, MT(ASCP)
   CAP Coordination Manager, Membership and
   Professional Development
   Email: bbarret@cap.org

   All materials become the property of the CAP and will not be returned.

Evaluation & Presentation

5. Incomplete nominations will not be considered. The CAP reserves the right to consider an individual or group of individuals for an award other than the one designated on the nomination form. Further, the CAP reserves the right to NOT confer an award in any given year.
6. Representatives from the CAP Member Engagement Committee and the Council on Membership and Professional Development will evaluate all nominations and recommend a slate of award candidates to the Board of Governors for its approval. The decisions of the Board are final.
7. No information about the nomination evaluation process and/or the nominees can be provided prior to the official notification of the award honorees.
8. Award candidates will be invited to accept their awards in person during CAP '15 – *THE Pathologists' Meeting*, October 4 – 7, 2015, Nashville, Tennessee.

COLLEGE of AMERICAN PATHOLOGISTS

Nomination Form

2015 CAP Meritorious Service Awards Program

Please read the *2015 CAP Meritorious Service Awards Program Nomination Form Instructions* before completing this form. On or before March 31, 2015, please complete and submit this nomination form along with the nominee's curriculum vitae (CV) or the nominees' curricula vitae (CVs) via e-mail to:

Barbara J. Barrett, MPA, CAE, MT(ASCP)
CAP Coordination Manager,
Membership and Professional Development
Email: bbarret@cap.org

Today's Date _____

Nominee's Contact Information

Nominee's Name (If nominating a team - list each member of the team)	
Nominee's Address	
Nominee's City/State/Zip Code	
Nominee's Telephone	
Nominee's E-mail Address	
Nominee is a CAP Member?	☐ Yes ☐ No

Nominator (Name & Email Address)

_____

Nominee(s) is/are aware of this nomination. ☐ Yes ☐ No

I nominate the above individual or group of individuals for the following award(s): Please check all that apply.

√	Award Name
	CAP Award for Specialty Advancement
	CAP Distinguished Patient Care Award
	CAP Distinguished Service Award
	CAP Lifetime Achievement Award
	CAP Outstanding Communicator Award
	CAP Public Service Award
	CAP Resident of the Year Award
	CAP Staff Outstanding Achievement Award

COLLEGE of AMERICAN PATHOLOGISTS

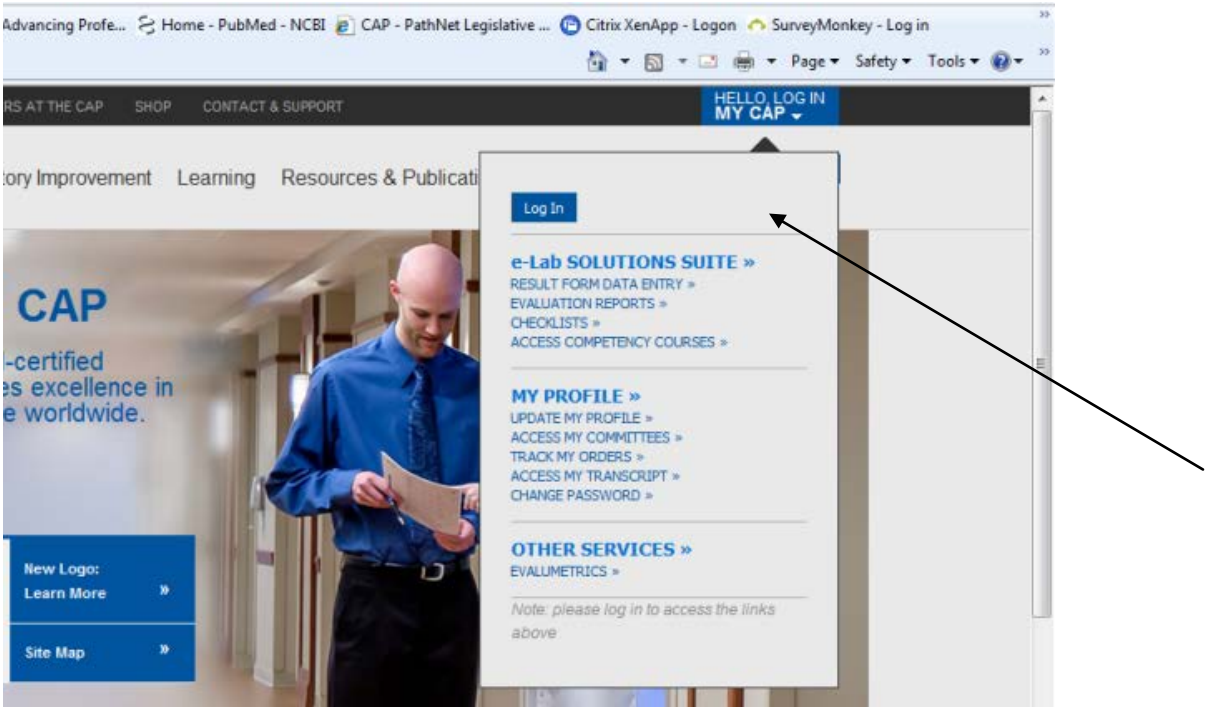
Nominator's Narrative Statement

Using not less than 50 but no more than 250 words in the space below, please describe the accomplishments and contributions exhibited by the nominee or the nominees (e.g. team) and explain why the nominee or nominees should receive a specific award. Attach the nominee's curriculum vitae (CV) or the nominees' curricula vitae (CVs) to your submission.

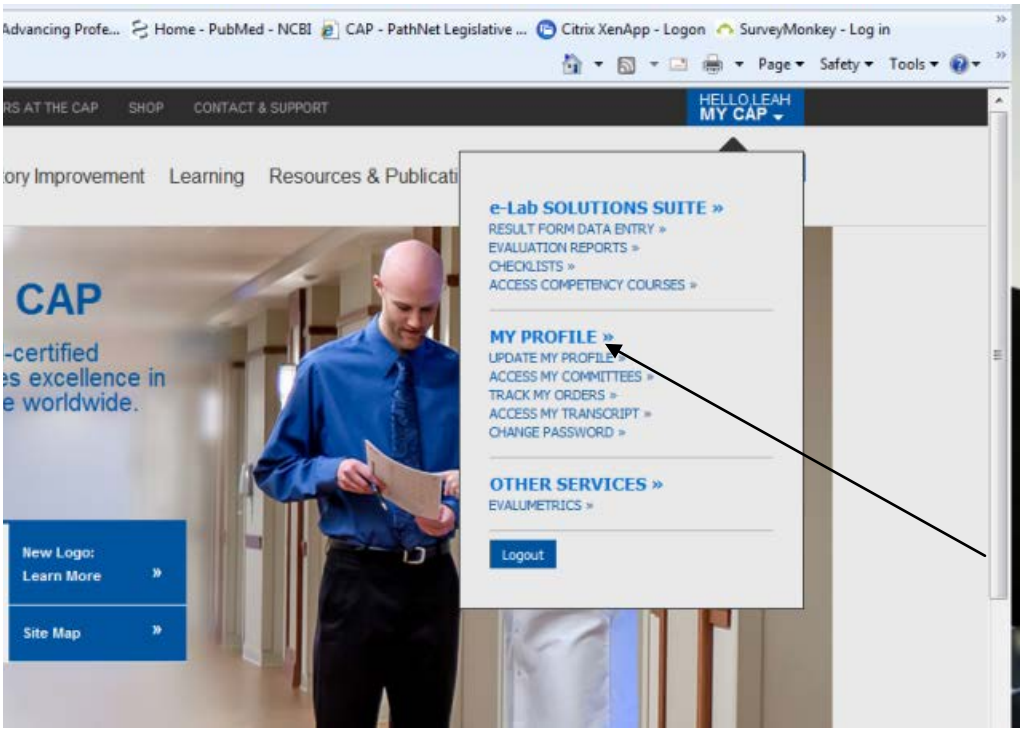
How to Update Your CAP Member Contact Information

Please update your member data online.

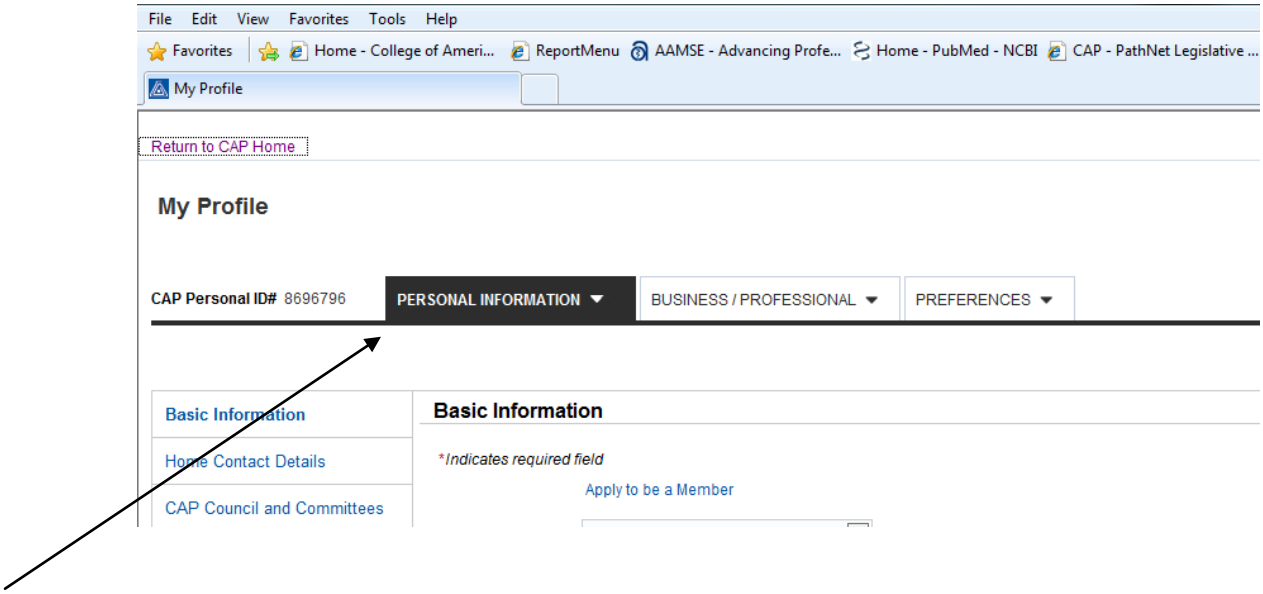
1. **Log in at www.cap.org** – (HELLO LOG IN **MY CAP**)



2. **Select Update My Profile in MY CAP dropdown**.



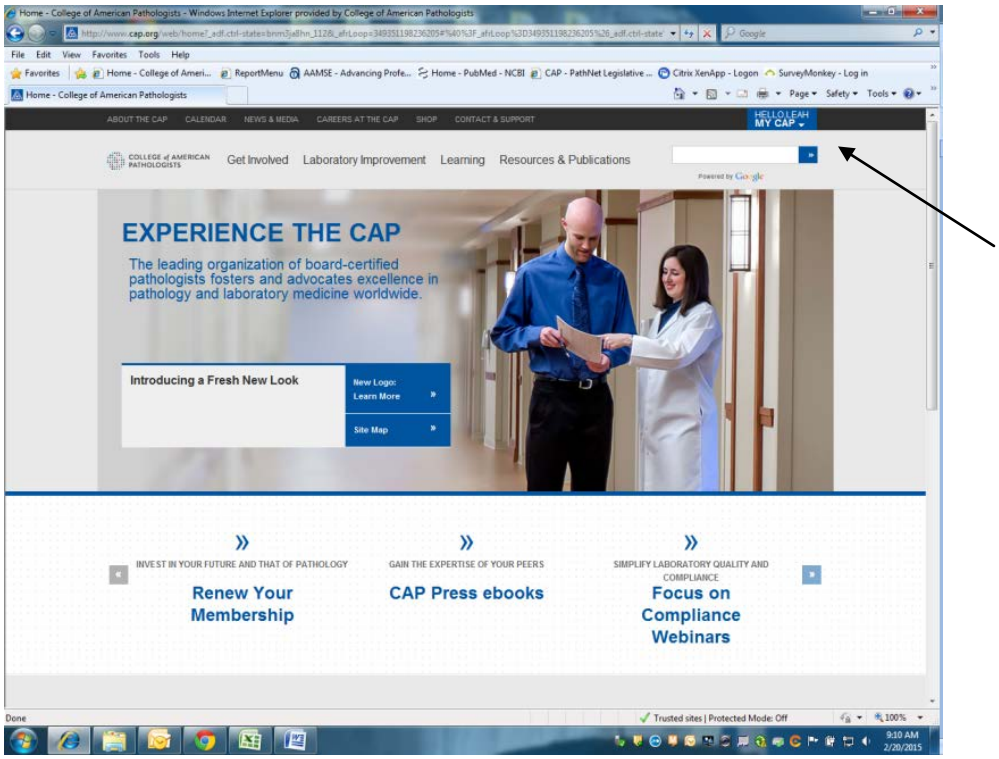
3. **Choose Change Personal and Professional Details under Personal Details.**



HOD Discussion Board Instructions and Guidelines

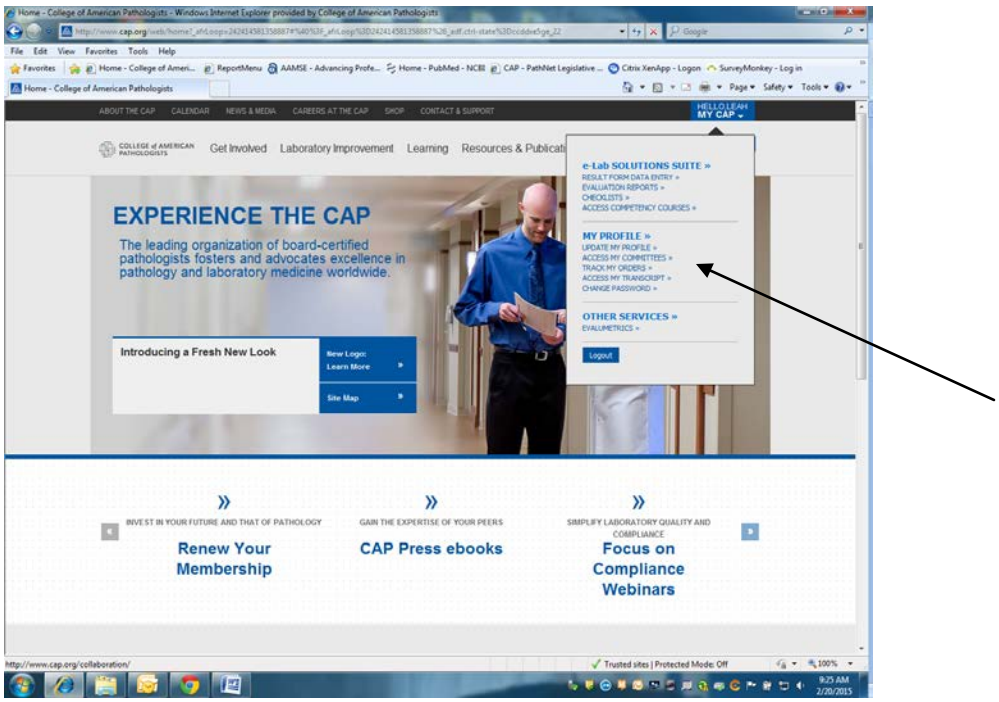
To Access the HOD Discussion Board follow the steps below:

1. Go to http://www.cap.org/collaboration/groups/HOD and log in.

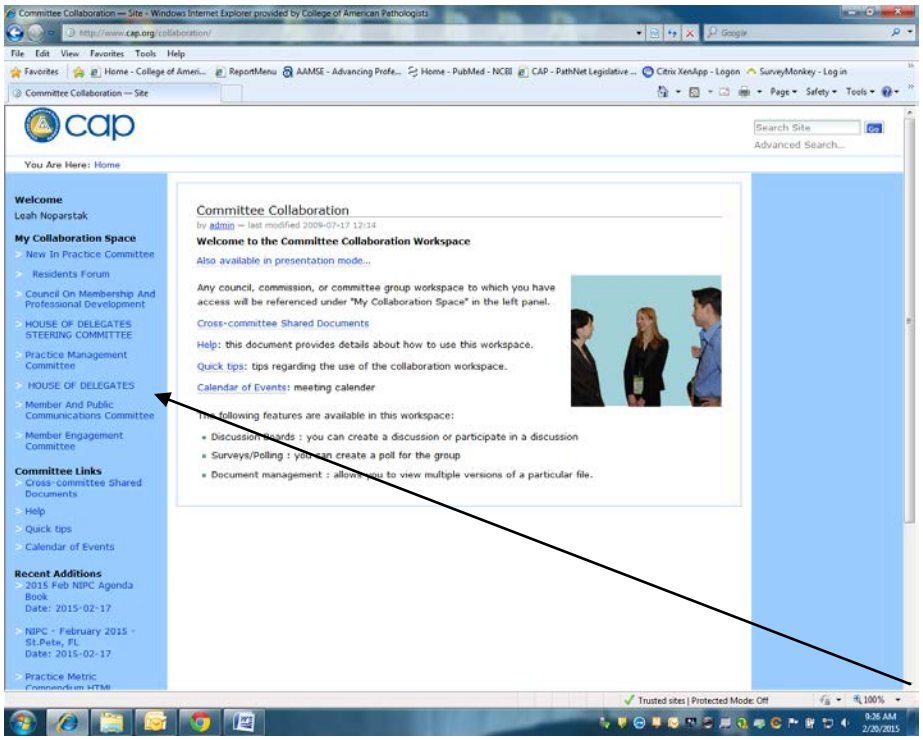


2. Save this site to your Favorites so you can easily access it again later.

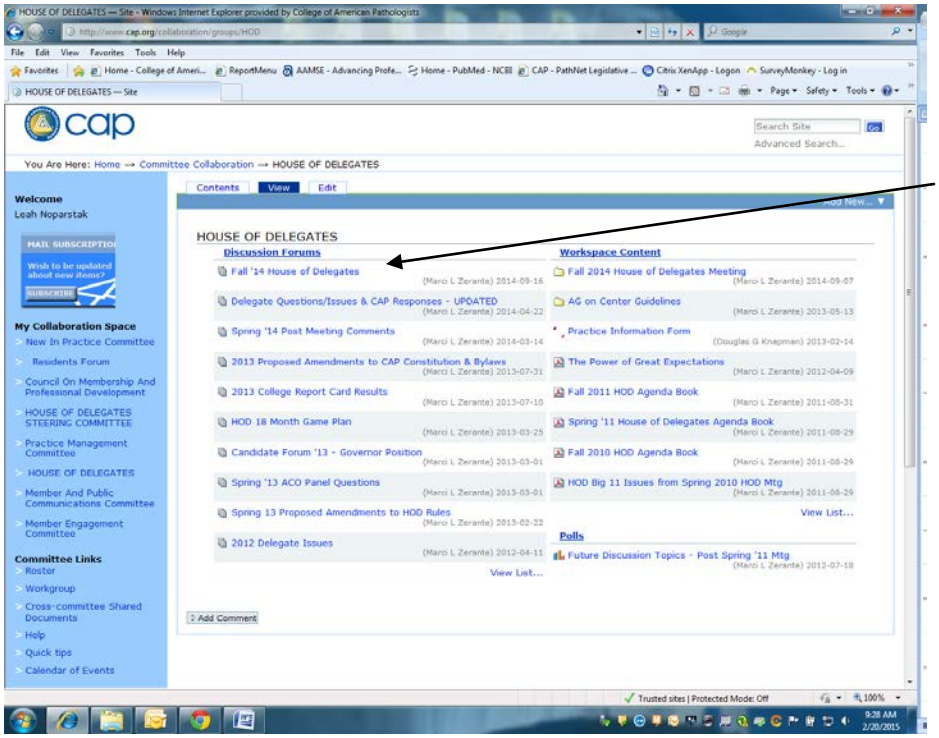
3. Click on the drop down box on upper **right** hand corner and under My Profile – choose **Access my Committees**



4. Click the link for HOUSE OF DELEGATES on the **left** hand navigation pane.

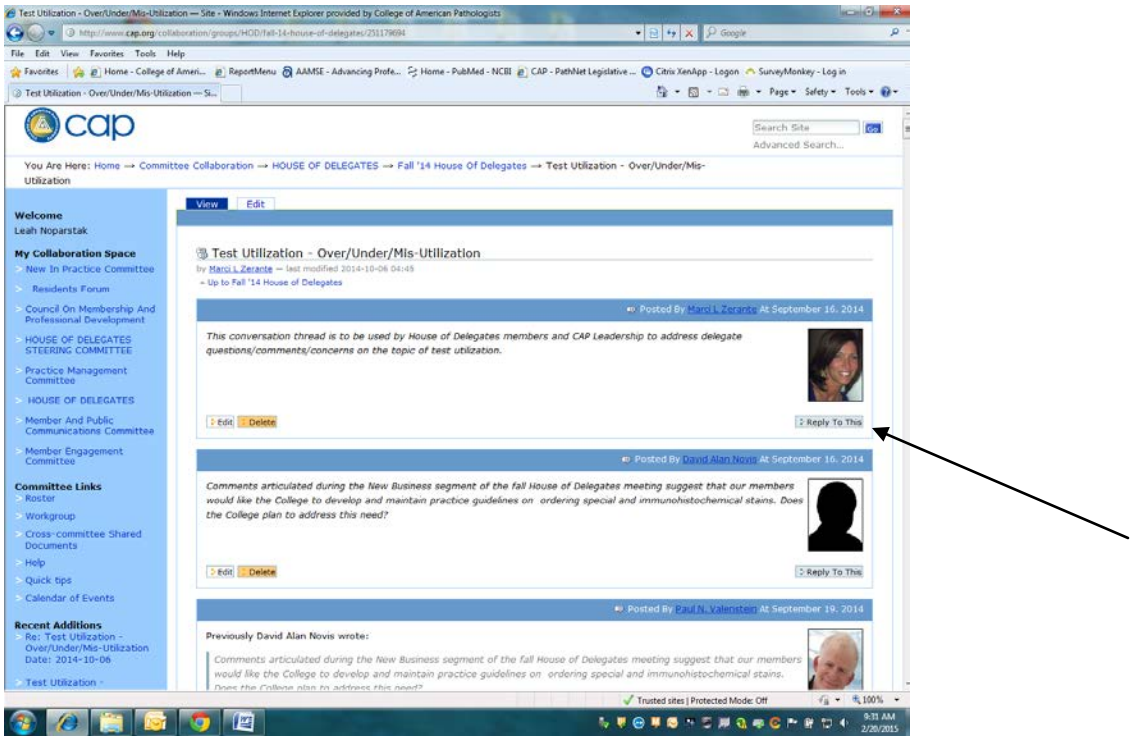


5. Click the **"Fall '14 House of Delegates"** Discussion Forum.

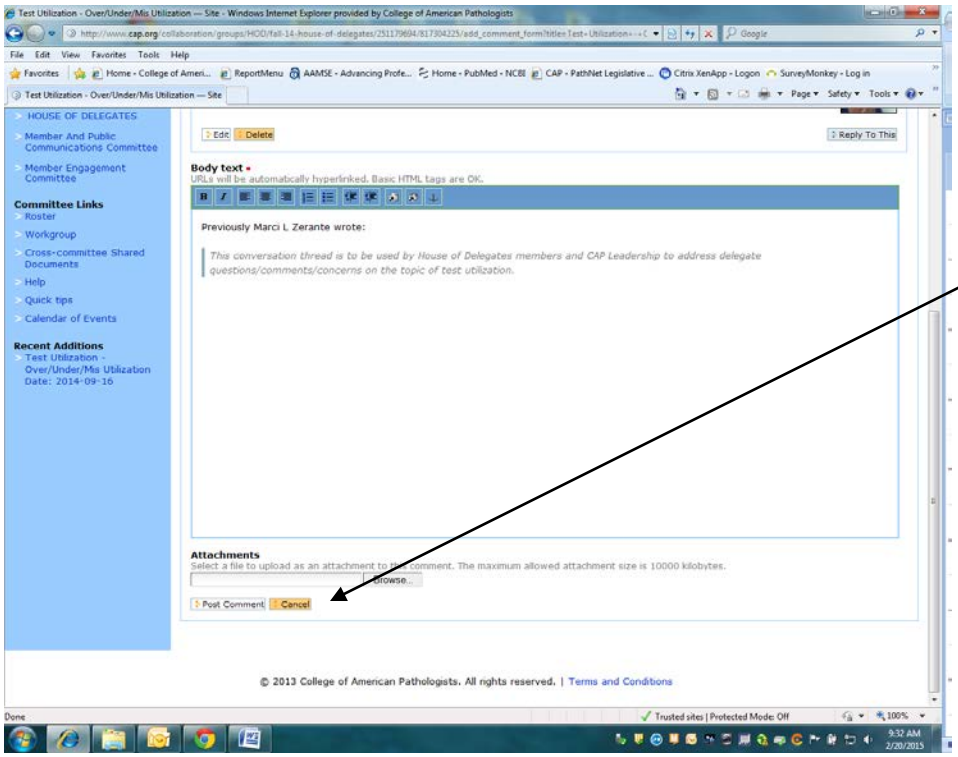


6. There are 3 conversation threads in this forum. Click on the Issue to open it to view the previous posts/responses.

7. Click the **“REPLY TO THIS”** button.

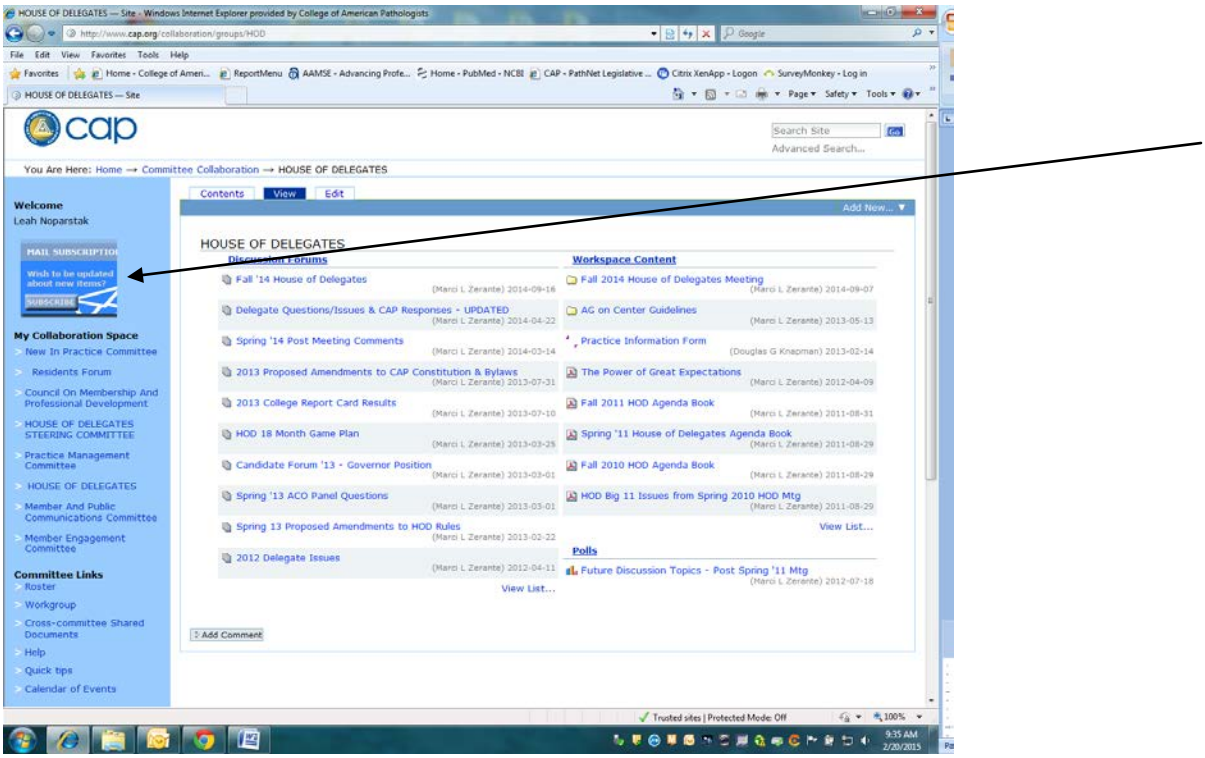


8. In the **“BODY TEXT”** box, type your response and then click the **“POST COMMENT”** button.



TO BE AUTOMATICALLY ALERTED WHEN A NEW COMMENT HAS BEEN POSTED

1. Once you are logged into the Collaboration Space, click the "**subscribe**" button in the MAIL SUBSCRIPTION box in the upper left hand navigation pane.



When posting your comments, please observe the following guidelines:

- Be clear and concise. If possible and appropriate, indicate upfront if you agree or disagree with the statement or issue to which you are responding. Avoid meaningless threads, one word (or short) nonsense posts, etc.
- Rudeness, profanity, insulting posts, personal attacks or purposeless inflammatory posts cannot be tolerated and will be removed.
- Please no advertising, spamming or trolling.
- Discussion of illegal activities such as antitrust violations is prohibited.
- While these guidelines cover most common situations, we cannot anticipate everything. In promoting the interests of all Delegates, there may be times when we must take actions to ensure that the HOD Forum is not disrupted or abused.
- We suggest that you never give out your log-in information to anyone. We are unable to prevent undesirable consequences that might arise should you disclose this information.

If you have any questions, please feel free to contact House Speaker, James E. Richard, DO, FCAP @ housespeaker@cap.org or CAP HOD Staff Jan Glas @ jglas@cap.org.

COLLEGE of AMERICAN PATHOLOGISTS

House of Delegates Member Expense Reimbursement Form

Please complete demographic and travel related information below.

Name			
Address			
City		**State**	**Zip**
Reason for Travel *(Please be specific, e.g. list full committee name.)*	**House of Delegates Meeting**		
Date(s) of Travel	**3/20 - 21/2015**	**Destination**	**Boston, MA**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Dates m/d/yy						**03/20/15**	**03/21/15**	
Air/Rail								**$0.00**
Hotel								**$0.00**
Meals								
Breakfast ($40)								**$0.00**
Lunch ($45)								**$0.00**
Dinner ($130)								**$0.00**
Auto								
Personal Auto [1] ***(Enter miles in line 30 below)***	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**
Auto Rental (include gas)								**$0.00**
Tolls/Parking								**$0.00**
Taxi								**$0.00**
Gratuities								**$0.00**
Miscellaneous [2]								**$0.00**
TOTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
# of Miles								

[1] *Personal car allowance = $0.575*

[2] *Includes up to $25 per day for phone, fax, internet connection, and health related activities (with proper documentation)*

Total Expenses Incurred		$0.00

For Office Use Only: Account Combination	Total
01-70-7095-59040-000000-00000	

House of Delegates Members are eligible for up to $100 reimbursement for attending one meeting per calendar year and up to $300 total for attending two meetings per calendar year. Receipt(s) must be submitted for expense amount claimed.

I hereby certify that the above expenses were incurred by me while on official business for the College of American Pathologists and that reimbursement is due me.

Signed _____ Date _____

I wish to donate my reimbursement to the CAP Foundation (please initial on the line to the right) _____

For Office Use Only: **Approved** **Date**

Please return form and receipts via fax to Leah Noparstak at 847-832-8438.

COLLEGE of AMERICAN PATHOLOGISTS

CAP Meritorious Service Awards Nominations – Deadline extended to March 31, 2015

Who of your colleagues can you acknowledge for their outstanding achievements and accomplishments?

Nominate them now for CAP awards.

See page 188 of this agenda book.

COLLEGE of AMERICAN PATHOLOGISTS

Save the Dates!

2015 Policy Meeting

May 4-6, 2015
Washington, DC

Fall ’15 House of Delegates Meeting

October 2-3, 2015
Nashville, TN

CAP ’15 – THE Pathologists’ Meeting™

October 4-7, 2015
Nashville, TN